

**The role of the Registered [Surgical] Nurse in the
21st century NHS Acute Trust hospital.
An ethnographic study.**

Della Sadler-Moore (Ms)

**S.R.N., M.Ed., B.Sc.Hons. Nursing., E.N.B. A25. Surgical Nursing.,
Dip. Clinical Teaching., R.C.N.T., Cert.Ed.(FE)., R.N.T.**

**A thesis submitted in fulfilment of the
requirements of the University of Wolverhampton
for the degree of Doctor of Philosophy (PhD).
August 2009.**

This work or any part thereof has not previously been presented in any form to the University or to any other body whether for the purposes of assessment, publication or for any other purpose. Save for any express acknowledgements, references and / or bibliographies cited in the work, I confirm that the intellectual content of the work is the result of my own efforts and of no other person.

The rights of Della Sadler-Moore to be identified as author of this work is asserted in accordance with ss.77 and 78 of the Copyright, Designs and Patents Act 1988. At this date copyright is owned by the author.

Signature:

Date: August 2009.

'Memory'.

Every present requires an understanding and appreciation of the past, without that perspective, we grow intolerant of the pace of change and our progress would be more often circular than it is already. Each new generation would repeat the errors and forget the successes of the preceding generation. Progress requires memory. Memory enables us to analyse where we have been, where we are going, and to generate new approaches for bettering our efforts. Therefore, it makes sense to examine the history of how we got there to here, and to explore some of the issues that influence the next step - a step forward (Bevis 1989).

Abstract.

This study focused on Registered Nurses (RNs) working in Acute Trust surgical wards in the context of their role development, role expansion and role extension. The study originated from concerns raised by RNs undertaking the surgical pathway of the BSc Hons in clinical nursing practice, who alerted me to their dissatisfaction with their working conditions and their role. This revelation was made at a time when modernization was cascading into Acute Trusts as a result of the NHS plan (DOH 2000); simultaneously the European Working Time Directive (EWTD) was being implemented, sequentially reducing Junior Doctor's hours of work. NHS modernization and the EWTD were the two initiatives which led the researcher to the assumption that RNs working in surgical wards were the labour force who would be absorbing the additional workload brought about by these changes, because RNs are the only health professionals in acute surgical wards with twenty-four hour contact with, and responsibility for, ward-based surgical patient care.

The study was conducted in one clinical directorate of an Acute Trust hospital, comprising six in-patient surgical wards and five specialist nursing services. The methodology was ethnography, where the researcher worked as an RN for fifteen months, collecting data through Spradley's (1980) descriptive, selective and focused phases of fieldwork. Data was analysed using what Miles and Huberman (1994) refer to as a set of 'choreographed / custom built' techniques.

The descriptive phase of fieldwork revealed an apparent 'staffing illusion' on the surgical wards and RNs were found to be under tremendous pressure to manage 'patient throughput', and an ever increasingly dependent case mix of surgical patients, within the existing, or if possible diminishing Senior / experienced RN labour force due to the emergent evidence of a 'cycle of staff change' with non-clinical managers backfilling Senior RN posts with Junior RNs. For Senior RNs this backdrop meant additional support and supervision demands on their role. To get through the workload many RNs held 'dual roles' to enable maintenance of the surgical services within the directorate.

The selective phase of fieldwork re-focused the ethnographic lens on the RNs in the context of their role development, role expansion and role extension, from which six perspectives were found: 1) role development from Junior to Senior RN, 2) role expansion dependent on shift of the day, day of the week - the co-ordinator role, 3) role extension confusion and boundary disputes, 4) hidden [role expansion and extension] talents of surgical nurses, 5) role contraction - a feeling Nursing is going backwards, and finally, 6) 'if only I could' - role expansion aspirations of surgical RNs. The third phase of fieldwork, described by Spradley (1980) as the focused phase, was spent validating the findings and conducting the ethnographic interviews.

The findings are interpreted locally [from the perspective of RN's working within Rodin] as 'working to full capacity' through 'doing more for more with less', as a result of the RN with the surgical directorate being sandwiched between two agendas, that of Junior Doctors EWTD and NHS modernisation. Braverman's skill substitution / degradation of skilled work thesis is then used as an interpretative framework to conclude the thesis, the outcome of which reports a 'triple substitution' agenda.

| | |
|--|-----------|
| ABSTRACT. | 3 |
| ACKNOWLEDGEMENTS..... | 7 |
| ABBREVIATIONS. | 8 |
| KEY TO TRANSCRIPTS. | 9 |
| DECLARATION OF ANONYMITY AND CONFIDENTIALITY. | 9 |
| LIST OF FIGURES. | 10 |
| LIST OF TABLES..... | 12 |
| LIST OF APPENDICES..... | 13 |
| INTRODUCTION..... | 14 |
| Why I studied what I studied..... | 14 |
| The research questions, empirical approach and interpretation of the findings. | 18 |
| Organisation of the thesis. | 23 |
| PART I: PROVIDING ‘NURSING’ SERVICES IN THE DISTRICT GENERAL / | |
| ACUTE TRUST HOSPITAL..... | 25 |
| Chapter 1:The rise and demise of the Registered [General] Nurse. | 26 |
| ERA 1: From ‘General Nurse’ (SRN) role development to role restriction..... | 26 |
| ERA 2: From ‘General Nurse’ role restriction to RGN professionalization. | 39 |
| ERA 3: The demise of the ‘General Nurse’ (RGN) and medical substitution. | 46 |
| ERA 4: From new roles for RNAs to anarchic government agendas..... | 63 |
| Chapter 2: ‘Assistants’ to the Registered [General] Nurse in Hospital wards. | 74 |
| ERA 1: Apprentices, true Nursing Assistants and Nursing Auxiliaries. | 74 |
| ERA 2: Substituting skilled trainees and trained assistants with support workers. | 81 |
| ERA 3. Formal training but no regulation of the New Nursing Assistants. | 88 |
| ERA 4: Who knows: Skilled, semi-skilled or un-skilled assistants in hospital wards | 90 |

| | |
|---|------------|
| Conclusion Part I..... | 94 |
| PART II: METHODOLOGY..... | 97 |
| Chapter 3: The empirical approach: ethnography. | 98 |
| Ethnography as methodology in this study..... | 99 |
| The research site and surgical nurses. | 102 |
| Getting my foot in the door: the survey period. | 104 |
| Ethnographic fieldwork. | 104 |
| Management of the ethnographic data..... | 110 |
| The interpretation process. | 120 |
| Being a moral, ethical RN ethnographer. | 123 |
| Establishing trustworthiness in this ethnographic study..... | 133 |
| Conclusion Part II. | 143 |
| PART III: THE ETHNOGRAPHIC FINDINGS..... | 144 |
| Chapter 4: Rodingham, The Rodin and the provision of surgical services..... | 145 |
| A decade of developments in Rodin's General Surgery and Urology Directorate..... | 148 |
| Managerialism in The Clinical Division of Surgery..... | 155 |
| The General Surgery and Urology Directorate..... | 162 |
| Chapter 5: The Surgical Nurse labour force and the conditions of production. | 176 |
| The Surgical 'Nursing' labour force..... | 176 |
| Staffing the surgical 'Nursing' services. | 194 |
| The conditions of Surgical Nurse production..... | 204 |
| Chapter 6: RN role development, role expansion and role extension in the surgical milieu. | 210 |
| From Junior to Senior [Surgical] RN. | 210 |
| Role expansion dependent on shift of the day and day of the week: the ward co-ordinator role..... | 221 |
| Role confusion and boundary disputes..... | 225 |
| Role contraction: the feeling Nursing is 'going backwards'. | 232 |
| Future role aspirations. | 240 |
| Extending the working week..... | 243 |
| Conclusion Part III..... | 246 |

| | |
|---|------------|
| PART IV: MODERNIZATION AND THE 21ST CENTURY REGISTERED | |
| [SURGICAL] NURSE. | 247 |
| Chapter 7: The Registered [Surgical] Nurse and modernization in Rodin..... | 248 |
| The ‘anticipated’ consequences of modernization for Rodin’s surgical RNs. | 254 |
| The ‘unanticipated’ consequences of modernization for Rodin’s surgical RNs. | 263 |
| Chapter 8: The 21st century role of the Registered Nurse. | 278 |
| The skilled craftsman RN..... | 278 |
| The concept ‘new’ in the occupational market of Nursing..... | 281 |
| ‘New’ Labour, new tactics: the scientific management of the NHS. | 284 |
| The purchasing of ‘dissociated elements’: the detail worker. | 287 |
| The disillusioned ‘old’ craftsmen. | 289 |
| The habituation of ‘new’ [nursing] personnel. | 291 |
| The final government act: re-classification of ‘nursing’ roles..... | 292 |
| Aah but: the unintended consequences of ‘skill’ substitution. | 295 |
| Conclusion Part IV: ‘Triple’ substitution. | 297 |
| CONCLUSION TO THE THESIS..... | 300 |
| Contribution to knowledge. | 301 |
| A Critical reflection on ethnography as methodology and the ‘other’ in the research journey..... | 304 |
| Recommendations, ‘unfinished business’. | 305 |
| REFERENCES..... | 307 |
| SELECTIVE BIBLIOGRAPHY..... | 330 |
| APPENDICES..... | 334 |

Acknowledgements.

This thesis is dedicated to Laurence, my son and heir. Throughout your formative years you have lived through this research journey, and at times I know you have been 'fed up' with my constant studying. I hope one day you will understand why I studied what I studied. May your apprenticeship to master craftsman journey be considerably less tortuous than mine has been.

As for Nanny and Grandpa (Kath and John), I thank you dearly for your social, psychological and financial support. The roles you played [the weekly washing, renovation of the home Laurence and I share and moral support] are in Goffman's words 'backstage'. Words cannot convey my thanks.

This brings me to Dr Andrew Cooper, a social scientist and my Director of Studies. I begin by thanking you for agreeing to supervise me. You have been a constant source of advice, a thoughtful, respectful colleague and a role model, but above all you have been a kind and considerate academic. I also thank Professor Rebecca Jester, my 'third' second supervisor in this research journey, it is always good to debate nursing; past, present and future with you. Thank you for your inspiration and support.

This study would have remained a theoretical, academic and an untold perspective on NHS care in England had it not been for my role in the university where post registration RNs alerted me to 'real life' issues affecting them in practice. Many of you participated in the research, I thank you all. I thought I knew what was 'going on in hospitals' until I worked with you. You are dedicated professionals caring for the most vulnerable in society, individuals whose work is remarkably uncelebrated. I hope in some way this thesis does justice to portraying your role and the conditions of production you are faced with.

Thanks go to my academic colleagues who have taken time to attend presentations, found time to discuss ideas and offered critiques of my work. Particular thanks go to some colleagues who listened to my moans and groans, and shared in my enthusiasm and frustrations throughout this journey.

One final person I would like to thank is Elizabeth Saunders, who following the viva diligently proof read and advised on editing to ensure good academic conventions were achieved prior to the thesis being placed in the public domain.

Abbreviations.

| | |
|----------------|--|
| AfC | Agenda for Change |
| ASAP | As Soon As Possible |
| C&G | City and Guilds |
| CF | Career Framework |
| DGH | District General Hospital |
| DOH | Department of Health |
| DVT | Deep Vein Thrombosis |
| EN | Enrolled Nurse |
| ENB | English National Board |
| EWTD | European Working Time Directive |
| FY1 | Foundation Year One |
| FY2 | Foundation Year Two |
| GMC | General Medical Council |
| GNC | General Nursing Council |
| GP | General Practitioner |
| HCA | Health Care Assistant |
| HE | Higher Education |
| HDU | High Dependency Unit |
| ICU | Intensive care unit |
| IWL | Improving Working Lives |
| JBCNS | Joint Board of Clinical Nursing Studies |
| JCC | Joint Consultant Committee |
| KSF | Knowledge and Skills Framework |
| NA | Nursing Auxiliary |
| NHS | National Health Service |
| NMC | Nursing and Midwifery Council |
| PREP | Post registration education and practice |
| PRHO | Pre Registration House Officer |
| RCN | Royal College of Nursing |
| RGN | Registered General Nurse |
| RN | Registered Nurse |
| RNA | Registered Nurse: Adult |
| RNT | Registered Nurse Tutor |
| RCS | Royal College of Surgeons |
| RSCN | Registered Sick Childrens Nurse |
| SEAN | State Enrolled Assistant Nurse |
| SEN | State Enrolled Nurse |
| SHO | Senior House Officer |
| SMAC | Standing Medical Advisory Committee |
| SNAC | Standing Nurse Advisory Committee |
| SRN | State Registered Nurse |
| UKCC | United Kingdom Central Council (for Nursing and Midwifery) |
| VAD | Voluntary Aid Detachment |
| WW | World War |

Key to transcripts.

- [] Background information added to make the context and/or meaning clear.
- ... Pause.
- (...) Words, phrases or sentences have been edited out.
- * From fieldnotes (not interview transcription).

The transcription conventions described above have been adapted from the seminal ethnographic text by Professor Paul E. Willis (1977, p. viiii).

Declaration of anonymity and confidentiality.

All fieldwork data presented in this thesis have been edited to preserve the respondents and their acute trust hospitals' anonymity, therefore all names used in the thesis are pseudonyms.

List of Figures.

| | | |
|-----------|---|-----|
| Figure 1 | Framework for reflexivity (Glaze 1998; 2002 based on Goodman 1984 levels of reflection). | 19 |
| Figure 2 | Sensitizing concepts discerned from Braverman (1974) Labour and Monopoly Capitalism. | 21 |
| Figure 3 | GNC 1919 Supplementary register. | 26 |
| Figure 4 | Three types of work in a hospital ward (Nuffield Provincial Trust 1953). | 29 |
| Figure 5 | Hospital patient nursing needs (Nuffield Provincial Trust 1953). | 29 |
| Figure 6 | The Nursing Process (adapted from Heath and Law 1982, p.7). | 34 |
| Figure 7 | Model of the pre-conditions leading to accountability (Bergman 1981, p55). | 42 |
| Figure 8 | Using information in managing the nursing resource: The Rainbow Pack (Greenhalgh and Company 1991). | 45 |
| Figure 9 | The scope of professional practice principles (UKCC 1992, p.6). | 47 |
| Figure 10 | The six activities (Greenhalgh and Company 1994). | 49 |
| Figure 11 | Questions regarding role expansion (Wright 1995, p.28). | 50 |
| Figure 12 | The real and potential drawbacks of new nursing roles (SODOH 1996, p.39). | 51 |
| Figure 13 | The ten key characteristics of Nursing practice (ENB 1991). | 52 |
| Figure 14 | Description of the three areas of specialist nursing practice (UKCC 1993). | 53 |
| Figure 15 | Eight recordable areas of specialist practice (UKCC 1994). | 55 |
| Figure 16 | Five ways to achieve the Vision for the Future (DOH 1993a, pp.v-ii). | 56 |
| Figure 17 | Breaking the Boundaries (Council of Deans 1998). | 58 |
| Figure 18 | 10 key roles for nurse (DOH 2001a). | 59 |
| Figure 19 | Levels of acute care (DOH 2000b). | 61 |
| Figure 20 | Essence of Care Benchmarks (DOH 2001). | 63 |
| Figure 21 | Four pillars of the NHS Human Resource strategy (DOH 2002d). | 65 |
| Figure 22 | Five key areas for 'systems re-engineering' in the NHS (DOH 2003a). | 66 |
| Figure 23 | Ten high impact changes (DOH 2004a). | 67 |
| Figure 24 | Three categories of workers for role re-design (DOH 2004a, p.10) | 67 |
| Figure 25 | The five pathways. Towards a framework for post registration nursing careers (DOH 2007). | 72 |
| Figure 26 | Eight core subjects for General Nurse examination (GNC 1939). | 74 |
| Figure 27 | EEC directives 77/452/EEC and 453/EEC (UKCC 1987a). | 81 |
| Figure 28 | Competencies for first level nurses Rule 18(1) (UKCC 1982). | 82 |
| Figure 29 | Second level nurse competencies Rule 18(2) (UKCC 1982). | 84 |
| Figure 30 | Support worker framework (DHSS 1989b). | 87 |
| Figure 31 | Assistants to the RN in Acute Trust wards. | 90 |
| Figure 32 | Second part of the Professional Register (NMC 2007). | 92 |
| Figure 33 | The work of the Health Care Assistant (Learn Direct 2007). | 93 |
| Figure 34 | The Skills and interests to be a Health Care Assistant (Learn Direct 2007). | 93 |
| Figure 35 | Health Care Assistant titles (RCN 2006b). | 94 |
| Figure 36 | Surgical Nurse activities observed and participated in. | 108 |
| Figure 37 | Cresswell (1998) Data analysis spiral. | 113 |

| | | |
|-----------|---|-----|
| Figure 38 | Fieldwork and data analysis phases (Spradley 1980; Wolcott 1984). | 113 |
| Figure 39 | Two cultural themes and associated descriptive concepts. | 115 |
| Figure 40 | Ladder of analytical abstraction (Carney 1990). | 116 |
| Figure 41 | Framework for conducting the ethnographic interviews. | 117 |
| Figure 42 | Research Ethics Wheel [REW] (Hammick 1997). | 125 |
| Figure 43 | The LREC experience ... An extract from journal 5, pp.39-42. | 128 |
| Figure 44 | Emerging criteria (Lincoln 1995, p.277). | 134 |
| Figure 45 | Member checking at different stages of the research journey. | 139 |
| Figure 46 | Rodin's organisational chart (from fieldwork document). | 147 |
| Figure 47 | The General Surgery and Urology directorate (from fieldnotes). | 148 |
| Figure 48 | Surgical Directorate Ward Philosophy and Ward Objectives (fieldwork document). | 152 |
| Figure 49 | Information booklet for patients on Primary Nursing (fieldwork document). | 153 |
| Figure 50 | Resume of Rodin's five year Strategy for Nursing. | 162 |
| Figure 51 | The structure of the General Surgery and Urology directorate at the time of fieldwork. | 163 |
| Figure 52 | Surgical ward layout. | 164 |
| Figure 53 | Two medical outlier case studies (from fieldnotes). | 171 |
| Figure 54 | Night Nurse Practitioner [NNP] Protocol (fieldwork document). | 183 |
| Figure 55 | A week in the life of Specialist Nurses. | 191 |
| Figure 56 | Summary of job description key duties of the new Ward Assistant grade (fieldwork document). | 193 |
| Figure 57 | Abridged version of critical care internal advert. | 194 |
| Figure 58 | Critical care in-house five day High Dependency training programme (fieldwork document). | 209 |
| Figure 59 | New RN's concerns regarding ward work (focus group mind map). | 211 |
| Figure 60 | The feeling Nursing is going backwards. | 239 |
| Figure 61 | The construct: 'working to full capacity' through 'doing more for more' 'with less'. | 254 |
| Figure 62 | Technical care requirements for an eight hour shift for a first day post operative bowel resection patient with a temporary stoma and diabetes. | 256 |
| Figure 63 | Fragmented care delivery: The APE & I model. | 265 |
| Figure 64 | The Hedge and Ditch Presumption (from Richards 1979). | 266 |

List of Tables.

| | | |
|----------|--|-----|
| Table 1 | The evolution of specialised educational opportunities for the General Nurse (adapted from Jolley and Darling 1982, pp.70-78). | 37 |
| Table 2 | UKCC (1991) 11 Part Professional register. | 39 |
| Table 3 | UKCC (1994) 15 Part Professional register. | 47 |
| Table 4 | The eight activities taking up most Junior Doctor time (Greenhalgh and Company 1994). | 48 |
| Table 5 | The Council's proposed three areas of specialist practice (UKCC 1993). | 54 |
| Table 6 | The new three part Professional Register (NMC 2004). | 64 |
| Table 7 | Recorded qualifications (NMC 2004). | 64 |
| Table 8 | The NHS career framework Levels 5-9 (Skills for Health 2007). | 68 |
| Table 9 | Conceptualisation of the four eras of Registered Nursing. | 72 |
| Table 10 | General student nurse modularisation apprenticeship (1987-1990). | 83 |
| Table 11 | NVQ levels 1-5 (Moore 1996). | 89 |
| Table 12 | Support worker bands 1-4 (Skills for Health 2007). | 91 |
| Table 13 | The three legislative nursing eras. | 95 |
| Table 14 | A comparison of clinical grading and Agenda for Change applied to hospital nursing services. | 96 |
| Table 15 | Trust profiling: data retrieved and sources utilized. | 105 |
| Table 16 | Final Cultural Inventory. | 119 |
| Table 17 | Cultural Inventory mapped against thesis chapters. | 121 |
| Table 18 | Additional themes generated during interpretation. | 123 |
| Table 19 | Applied Ethical plan. | 126 |
| Table 20 | Senior Nurse profiles. | 150 |
| Table 21 | Surgical Clinical placements during RN Diploma training. | 215 |
| Table 22 | Ward Nursing establishment changes at Primary Nurse / AfC band 6 over five years. | 221 |
| Table 23 | Contrasting critical care nursing and surgical nursing - the environments of the labour force. | 236 |
| Table 24 | Critical Care provided training programmes. | 238 |
| Table 25 | Professional registration: Occupational re-classification. | 297 |

List of Appendices.

| | | |
|-------------|--|-----|
| Appendix 1 | Detailed descriptors of the three kinds of ward work (Nuffield Goddard 1953). | 334 |
| Appendix 2 | Technical Nursing Procedures (Nuffield Goddard 1953). | 336 |
| Appendix 3 | The Briggs recommendations (HMSO 1972, pp.212-217). | 337 |
| Appendix 4 | Strategy for Nursing (DOH 1989). | 342 |
| Appendix 5 | Summary of the virtue of patients (Audit commission 1991). | 345 |
| Appendix 6 | List of activities (Greenhalgh and Company 1994). | 349 |
| Appendix 7 | Report recommendations (Greenhalgh and Company 1994). | 350 |
| Appendix 8 | Benefits of Nurses' role expansion (SODOH 1995). | 352 |
| Appendix 9 | Key characteristics and associated learning outcomes (ENB 1992). | 353 |
| Appendix 10 | Vision for the future: 12 targets (DOH 1993). | 359 |
| Appendix 11 | Making a difference: resume (DOH 1999). | 361 |
| Appendix 12 | Peach Report recommendations (UKCC 1999). | 365 |
| Appendix 13 | Four statutory practical assessments (GNC 1969). | 369 |
| Appendix 14 | Revised nomenclature (BJN 1935). | 374 |
| Appendix 15 | Organizational literature retrieved during fieldwork. | 375 |
| Appendix 16 | Example word processed fieldnotes. | 379 |
| Appendix 17 | Example page of a transcribed interview. | 380 |
| Appendix 18 | Example page of 'tagged' interview text. | 381 |
| Appendix 19 | Example 'codebook' following interview analysis. | 382 |
| Appendix 20 | 35 themes. | 385 |
| Appendix 21 | Interview mind map. | 386 |
| Appendix 22 | Overview of the ethnographic data analysis process. | 387 |
| Appendix 23 | Cultural Inventory themes: mapped by Part III chapters. | 390 |
| Appendix 24 | Outcome of using the REW (Hammick 1997) for 'ethical self scrutiny'. | 393 |
| Appendix 25 | Senior Nurse meeting: information pack. | 397 |
| Appendix 26 | Written Surgical Nurse consent for fieldwork. | 403 |
| Appendix 27 | Written Surgical Nurse interview consent pack. | 404 |
| Appendix 28 | Surgical patient consent. | 406 |
| Appendix 29 | Trust five year Strategy for Nursing. | 407 |
| Appendix 30 | Directorate Surgical Activity. | 411 |
| Appendix 31 | Ward patient profile. | 412 |
| Appendix 32 | NNP: first point of contact protocol. | 413 |
| Appendix 33 | Retention strategy. | 415 |
| Appendix 34 | Surgical Competency development programme. | 416 |
| Appendix 35 | Spreadsheet re. fledglings clinical practice placements. | 419 |
| Appendix 36 | A focused literature review expanding debates in relation to some findings reported in this thesis | 421 |
| Appendix 37 | Paper presented at the International Labour Process Conference (ILPC) Edinburgh 2009. | 457 |
| Appendix 38 | Evidence available for auditing the research process and product. | 478 |

Introduction.

This is a study of the Registered Nurse (RN) employed in the National Health Service (NHS) Acute Trust general surgery and urology wards¹. The focus of the research is the RN's post registration role development, role expansion and role extension, and a study conducted at a moment in time when the NHS in England is in an unprecedented era of structural change, referred to as modernisation, emanating from New Labour's NHS Plan (DOH 2000a).

It is often a mystery as to why an academic studies a particular topic, a situation which stimulated Okely and Callaway (1992) to propose the need for more intellectual autobiographies to clarify why an academic studies what he / she does. Although as Coffey (1999) points out, there is no agreement as to the amount of self disclosure required to fulfill this request. In view of the lack of consensus on researcher self disclosure, I now offer a 'resume' from where my interest derives for studying the RN employed within Acute Trust Hospital non critical care surgical wards.

Why I studied what I studied.

Following my own Registration as a General Nurse (SRN) I spent a decade specializing in a District General Hospital (DGH) as a Surgical Nurse, eventually moving into nurse education to teach surgical care to General student nurses in the classroom and practice setting. In 1992 the School of Nursing began delivering the English National Board (ENB) Higher Award, the first clinically based, undergraduate programme with professional and Higher Education (HE) accreditation for RNs in England. A pre-requisite for RNs to enter the top-up

¹ **General Surgery and Urology Wards:** Not critical care and high dependency wards / units which also cater for the needs of surgical patients, and not day surgery wards / units which can also be found in the Acute Trust.

ENB Higher Award Degree was a recordable specialist clinical nursing course². Because there was no professionally recordable course for RNs working within the specialism General Surgery / Urology, the School of Nursing implemented the ENB A25 Surgical Nursing course, a recordable clinical course comparable to the more longstanding surgical sub-speciality courses for RNs working in orthopaedics [ENB 219] and ophthalmology [ENB 338]. I was appointed to lead the first English diploma level ENB A25 Surgical Nursing course. As hospital based Schools of Nursing integrated into HE, the ENB framework for post registration nurse education evolved into a post registration clinical nursing degree; up to today I retain my role as the undergraduate surgical nurse pathway route leader.

On publication of the United Kingdom Central Council (UKCC) Scope of Professional Practice guidelines (UKCC 1992a), which made RNs accountable for their role development, as opposed to their role being restricted by medical delegation, previously mandated in the extending role Health Circular (DHSS 1977), I adopted the Scope of Professional Practice as my professional subject, lecturing across the school portfolio on the logistics of RN role development, role expansion and role extension. As a result of becoming known for my interest in the hospital RN's role I was seconded to an Acute Trust to co-ordinate systems for RN role expansion and role extension, a position lasting seven years, during which I conducted a trustwide survey, chaired a steering group and implemented policies, protocols and training for RN up-skilling.

Simultaneously with the NHS secondment I secured a one day a week independent hospital contract at the height of their implementing 'Managed Care'³. For five years I worked strategically at BUPA headquarters, planning for

² **Recordable specialist clinical nursing course:** Courses for RNs approved by either the Joint Board of Clinical Nursing Studies (JBCNS) or the English National Board (ENB), for example the Coronary Care Course.

³ **Managed Care:** described as quality, cost-effective patient focused care , achieved through multidisciplinary collaboration and teamwork (Laxade and Hale 1995).

the 'best use' of nursing resources, and operationally in a regional hospital where I was party to scrutinizing the nursing labour process, developing and implementing surgical pathways of care, and contributing to structural change which led to a cheapening of nursing labour costs through substituting RNs with Health Care Assistants (HCAs).

Having experienced surgical service provision in both NHS and Independent hospitals, combined with my academic interest in the role of the surgical RN I became aware of New Labour's modernisation of the NHS gaining momentum following the launch of the NHS Plan (DOH 2000a), which was occurring simultaneously with implementation of the European Working Time Directive (EWTD), the latter triggering a sequential reduction in the number of hours worked by Junior Hospital Doctors, often referred to as the Improving Working Lives (IWL) agenda. In my academic role with NHS employed RNs undertaking the top-up surgical degree, their comments about poor nurse staffing levels, and their references to increasing demands for them to undertake jobs previously in the domain of Junior Doctors, led me to become curious about Acute Trust working conditions. These RN concerns were initially raised in the safe environment of the HE classroom, but increasingly became expressed in assignments, concerns in stark contrast to the published literature on RN role development from which I was lecturing.

This theory-practice dichotomy, combined with my understanding at the time of the government modernization agenda, are the drivers which provided the impetus for the study now presented. The assumption on commencing the study was that RNs working on surgical wards, because they are the only professionally regulated labour force with twenty-four hour direct contact with, and responsibility for, surgical in-patient care, would be the occupational group most affected by New Labour's modernization agenda and the Junior Doctors' EWTD changes. RNs were presumed on commencing this research to be responding to changes in Acute Trust hospital surgical patient care brought about by New

Labour's surgical waiting list targets and the Junior Doctors' IWL agenda. This would therefore be a moment in time when RN responses to modernization and the EWTd could be captured through empirical research.

Contemporary empirical studies of the Surgical RN do exist: for example, MacLeod (1996) explored 'becoming experienced' with surgical ward sisters in Scotland, McCormack (1992) studied Primary Nursing in surgical wards, and more recently Wakefield (1998) described the 'private work' of the ward-based surgical nurse. Empirical studies also exist in relation to RN's role expansion and role extension, but, have in the main comprised national and regional surveys of expanded role activities (Land, Ni Maholrunagh and Castledine 1996; UKCC 1997a, 2000a), evolving nursing titles (SODOH 1995; Read with the ENRiP team 2001), the impact of changes to legislation (Finlay 2000) and nurses' perceptions (Leonard 1999). No studies have focused on the day-to-day role of the RN working within Acute, non-critical care General Surgery and Urology wards, and how within an era of NHS modernization, the RN is managing his or her role, what Willis and Trondman (2000) refer to as the 'nitty gritty' of everyday activities.

Having reviewed the literature to ensure my assumptions could not be answered using existing theory, and to confirm I was not duplicating previous work, I adopted a no 'a priori' theoretical framework for collecting the empirical data, so presented here is my original contribution to the academic community through 'setting down a major piece of new information in writing for the first time' (Francis 1976).

Although health policy is shifting towards providing elective surgical services within a mixed economy ethos, as seen through the increased provision of elective surgical services within the independent health care sector, the majority of surgical services for the people of England continue to be provided in Acute NHS Hospitals, particularly for those undergoing major planned and

emergency surgical procedures. A significant proportion of NHS RNs care for these vulnerable surgical patients within acute general surgery and urology wards.

The work of the hospital RN within the Acute Trust surgical milieu is regularly depicted in the media⁴, but as Bellamy Foster (1998) suggests, 'the real world of work in today's society is a mystery' (p.ix), because the prevailing ideology of popular culture is one of consumption, resulting in the more fundamental realities of work receding into the background, seldom depicted in any detail and when depicted are usually in a romanticized form. The study you are about to engage with is currently essential for RNs in NHS surgical wards because

it is an increasing imperative for all social groups to find and make their roots, routes and 'lived' meanings in societies undergoing profound processes of re-structuration and de-traditionalization, processes which are eroding the certainties of previous transitions and inherited cultures, as well as inciting them to re-establish themselves in new forms (Willis and Trondman 2000, p.8).

The research questions, empirical approach and interpretation of the findings.

Ethnography was deemed the most appropriate methodological approach to explore and experience the 'day to day' RN role over a prolonged period before theorizing on their role development, role expansion and role extension. Malinowski (1922) proposed the starting point of ethnographic research to be a set of questions, or 'foreshadowed problems' from which fieldwork begins, rather than a set of pre-conceived ideas to be proved or supported. To avoid the latter, research questions were constructed in an open manner to facilitate observation and discussion with RNs;

1. What are the central tenets of the RN role in the surgical milieu ?
2. In what ways, by what methods and for what reasons are RNs developing, expanding or extending their role within the surgical milieu ?

⁴ Current terrestrial television programmes transmitted in England regarding health care, particularly hospital care include: Holby City (BBC1), Casualty (BBC1), ER (Channel 4), House (Channel 5) and Grey's Anatomy (Channel 5).

3. How do RNs respond to demands for development, extension and expansion of their role ?
4. In what ways do RNs actively construct their role boundaries ?
5. What are RNs critical perspectives on their role within the surgical milieu?

From its inception the study has been naturalistic (Guba and Lincoln 1981), the aim being to inductively shed light on the RN's role within the surgical milieu. Glaze's (1998; 2002) framework for reflection, was adopted to operationalize Reflexivity, shown in figure 1.

A framework which encouraged ongoing engagement with the literature to aid understanding and interpretation of empirical data, and challenging of one's own assumptions during the research process. A journal was maintained throughout the research in which the practical aspects of the research process and theoretical interpretations were recorded.

Figure 1: Framework for reflexivity (Glaze 1998,2002, based on Goodman's (1984) levels of reflection.

- Level 1: Establish what did or did not work in a particular situation.
Identify what to do [differently] next time.
- Level 2: Inform reflections by a literature search and review [to inform analysis].
Ask yourself: are there theories to shed light on actions or guide analysis ?
- Level 3: Ask yourself: are you trapped in your old world view ? have you considered wider social forces and issues of justice and emancipation? are there wider political considerations to the issues raised ?

Analysis of the ethnographic data unearthed the non-clinical management agenda of sequential erosion of experienced 'old' style prepared Senior RN's and their replacement with Junior 'new' style prepared Adult RN's and currently unregulated Health Care Assistants (HCAs). Through application of Glaze's reflective framework I was led to Braverman's (1974) skill substitution thesis, because the process of replacing the 'old' with the 'new' labour force⁵, is a management strategy / process Braverman indicated can result in unanticipated

⁵ In this case General trained RNs with generalist prepared Adult RNs, and unregulated Health Care Assistants.

and adverse consequences, which in this study were found in relation to surgical patient outcomes and the conditions of RN production.

Braverman's skill substitution / degradation of skilled work thesis is based on 'labour process theory', the foundations of which were laid by Marx, but as Knights and Willmott (1990) point out Marx had little impact on the study of work until the publication of *Labor and Monopoly Capitalism* (Braverman 1974), the primary focus of which was the degradation of work in the twentieth century, brought about by a relentless tightening of management control of the skilled labour force (ibid., p.7). In the opening to his thesis Braverman criticised Marx for having evolved an incomplete, three phase version of capitalist transformation, a claim he based on there being a fourth phase, where management institute processes to reverse craftsman control of the production process into their hands, resulting in the skilled craftsman becoming de-skilled and disillusioned.

Braverman's degradation of skilled work is based on the premise that the unique human contribution to society by the craftsman is their unity of conception and execution, in this study the RN is viewed in Braverman's terms to be the 'skilled craftsman'. Through management's application of scientific management principles and techniques a purposeful act of dissolution of the craftsman's human endeavor (dissolution of the unity of conception and execution) is achieved, and a process Braverman suggests governs all forms of work in capitalist society, despite it being presented as a method to preserve scarce skills by putting skilled, technically trained workers to tasks only they can perform.

This study focuses on the RNs who in Braverman's terms are interpreted as the 'skilled' Nursing labour force in the acute trust surgical service industry. From Braverman's seminal text I have discerned a set of sensitizing concepts related to the process of degrading skilled work, listed in figure 2, concepts used to

shed light on and interpret the majority of the grounded ethnographic findings in this study.

Figure 2: Sensitising concepts discerned from Braverman's (1974) Labor and Monopoly capitalism.

- **'Skilled craftsmanship'** - apprenticeship based - unity of conception and execution (the human endeavour).
- The **concept 'NEW'** in the occupational market.
- Employer sees skilled craftsman as **'expensive'**.
- Employer believes there are **'equivalents'** to the skilled craftsman.
- Management application of **'Tayloristic principles'** aimed at 'reversal of production process control'.
- Creation of **New 'paper occupations'**.
- Employer **'purchases dissociated elements'** in the form of un/semi-skilled (skill substitution), the effect being cheapening of labour force costs.
- New employees **'habituated'**.
- **'OLD craftsman disillusioned'**, but has an infinitely malleable character.
- Government role: **'Re-classification of occupations'** (un /semi-skilled upgraded).
- Standards altered over several generations; **'Unintended consequences'** through purchasing an undefined quality and quantity.

As an RN myself, I have chosen to interpret the ethnographic findings as the de-gradation of skilled RN work, and how government and local non-clinical management have gained control of the RN production process. Like Braverman I was prepared under the apprenticeship system to the level of skilled craftsman, my craft, and the craft explored in this thesis being the skilled RN for the medically and surgically sick hospitalised patient, who over several generations have had their preparation for practice and 'title' altered (from SRN, to RGN, to RNA), alongside the recording of their post registration

specialist professional qualifications and their educational opportunities to pursue these.

Braverman's degradation of work thesis has not up to this point been utilized to interpret the effects of New Labour modernization of the English NHS on the RN labour force in the acute trust hospital. Brannon (1990) studied nursing work in the USA, applying Braverman's labour process analysis to shed light on changes affecting the RN, a study culminating in Brannon suggesting

Braverman provides an opportunity to move labour process analysis beyond factory production ... to the study of a major sector of service labor in advanced capitalist society (ibid., p. 511).

Braverman's important contribution to analysis and theorising on processes in the workplace, including de-skilling are summed up by Littler (1982) as:

1. Those on the shopfloor lose the right to design and plan work
2. The fragmentation of work into meaningless segments
3. A re-distribution of tasks amongst un /semi-skilled labour: associated with labour cheapening
4. The transformation of work organization from a craft system to modern taylorised forms of labour control.

Whilst Braverman's work was based on the manufacturing sector, application of elements of his thesis to my thesis are made because skill substitution and de-skilling of the craftsman RN labour force is a factor of production increasingly occurring in the English NHS. The outcome of this agenda Braverman viewed as having unanticipated consequences, which in this study were found in relation to the RN role and surgical patient outcomes.

Because Braverman's thesis on the degradation of skilled, apprenticeship based work does not provide an overarching theory to interpret all the findings unearthed in this ethnographic study, additional theories are used to interpret some of the empirical data, these include the hedge and ditch presumption (Davies 1979), work intensification (Mather, Worrall and Seifert 2005), marginalization (Hall, Stevens and Meleis 1994) and the recent work of Shields and Watson (2007) on the demise of the nursing profession. The overall

approach to interpretation of the ethnographic data is therefore eclectic, middle range theorizing. Whilst Toffler (1970) predicted the speed of change in society would be exponential, no one could have predicted over the five year lifetime of this study the speed and magnitude of change in relation to the provision of health care would be so unprecedented in the history of the NHS.

Organisation of the thesis.

Following this introduction the thesis is presented in four parts. Part I, the provision of Nursing Services in the District General / Acute Trust focuses on the historical, political and structural forces which have shaped the provision of Nursing services to patients in acute hospital surgical wards. Part I is presented in two chapters because what constitutes the work domain termed 'nursing' has since the passing of the 1919 Nurses Act been the subject of much fluctuation, debate and change between RNs and their assistants. From Braverman's perspective the RN is viewed as the 'Skilled' Nursing labour force, whilst 'assistants' are viewed as the training, trained or untrained, what Braverman refer to as the semi and un-skilled labour force.

Part II comprises a single chapter dedicated to the methodology, which concentrates on the empirical approach through outlining why ethnography was deemed the most appropriate approach for studying the RN role. This is followed by all aspects of the ethnographic process being laid bare, for the reader to understand and finally judge the quality of the ethnographic methodology and methods.

Part III presents the empirical findings, the aim being to remain 'very faithful' to the ethnographic data through providing a vivid picture of the work roles of the surgical RNs, and their working conditions within the surgical milieu; Part III is presented in three chapters.

Part IV turns to interpretation of the ethnographic findings, and comprises two chapters. Chapter seven presents an interpretation of the RN role within the Rodin Hospital where the study was conducted exploring the forces which juxtapose 'old' and 'new' RNs that have come into play resulting in RNs 'doing more for more with less' due to their 'working to full capacity'. Finally in Chapter Eight: The 21st century role of the RN offers an application of Braverman's skill substitution thesis.

In the conclusion the threads of the thesis are drawn together, and I spend some time offering a critical reflection on conducting the study and some thoughts on improving the RN situation to benefit the sick, most vulnerable patients in the surgical arena of the 'Acute Trust', which is as Dingwall and McIntosh (1978) remind us 'a hospital' ...

If we think about a hospital, what is there we can point to, other than bricks and mortar, and say 'this is a hospital'. A hospital has no material existence. It is not a thing. A hospital is an organisation, which is really a shorthand way of saying 'an organisation of social actions'. When we are talking about a hospital, we are talking about an idea towards which a whole collection of individuals orient their actions (p.9).

Part I: Providing 'Nursing' services in the District General / Acute Trust Hospital.

Part I is not a conventional critical review of a body of literature, although I did consider the bodies of knowledge on 'role', 'professionalization', 'specialization' and 'power' in relation to nursing. In concluding this survey I decided not to focus on these bodies of knowledge for two reasons. First, because I had adopted a no 'a priori' theoretical framework for conducting the iterative process of fieldwork and data analysis, after writing up the ethnographic findings it seemed inappropriate to retrospectively impose a framework on the findings, because through adopting Glazes' model of reflection, I had been led to Braverman's degradation of work / skill substitution thesis for interpreting the findings. Second, throughout fieldwork a constant assertion by Senior RNs was 'nursing is going backwards', which led me to ask the question 'how has hospital nursing evolved ?', before being able to shed light on the Senior RNs 'going backwards' theme.

To shed light on this question I looked to the literature, only to find the absence of a composite account of the development of General Hospital nursing services. Therefore I embarked on an archaeological journey, with the aim of discovering and documenting the factors that have served to shape hospital nursing practice, the starting point being the origin of regulated nursing for the hospitalised adult medically and surgically sick, the 1919 Nurses Act. The product of this journey of discovery is now presented in Part I as a narrative chronology.

Because what constitutes 'Nursing work' is a contestable concept, I have taken Braverman's distinction between the skilled (craftsman) and the semi/un-skilled (detail workers), the former RNs and the latter Assistants to structure Part I into two chapters. Both chapters are structured into four eras, a framework synthesized by the author, commencement of each era is denoted by structural changes which enabled or restricted opportunities for the RNs or their Assistants to develop, extend or expand their role.

Chapter 1: The rise and demise of the Registered [General] Nurse.

Passing of the 1919 Nurses Act brought into being the General Nursing Council (GNC) for England and Wales, and registration of six 'types' of trained Nurse providing care for the hospitalised sick. In addition to the GNC regulating Nurses working with the hospitalised sick, training and registration was in existence for Nurses working in the community, namely the District Nurse (commenced 1874), School Nurse (commenced 1891), Health Visitor (commenced 1862) and Industrial Nurse (commenced 1878). Midwives were also regulated since passing of the Midwives Act in 1902.

The first GNC register comprised a 'General' Register for nurses trained in care of the hospitalised General Surgery and General Medical patient, the SRN, and a 'Supplementary Register' with five divisions shown in figure 3. Following a period in which existing trained Nurses could gain GNC registration, penalties were introduced for those unlawfully assuming the title Nurse. Masson (1985) described passing of the 1919 Nurses Act as

Figure 3: GNC 1919 Supplementary register.

- *Male Nurses.
- *Infectious disease (Fever Nursing, discontinued 1967).
- *Sick Childrens Nursing.
- *Mental Nursing.
- *Nurses for Mental Defectives.

The most important measure for protection of the public from the untrained and ignorant. For the first time it put the nursing profession upon a proper basis regarding training and qualification (p.120).

ERA 1: From 'General Nurse' (SRN) role development to role restriction.

This era spans 58 years (1919 to 1977), during which no structures were in place to restrict the General Nurses' role development. SRN preparation was established by the GNC and applied through an apprenticeship where the Student Nurse was an employee in their training hospital, learning their craft of

caring for the adult medically and surgically sick from student nurse apprentices and SRNs. At the inaugural GNC conference Miss Lloyd Still, Chair of the Education and Examination Committee provided insight into the role of the General Nurse as a result of the new GNC syllabus;

The general aim should be to stimulate and foster the nurse's powers of development; to increase her capacity by a more extensive knowledge of subjects - scientific, social, practical - pertaining to her profession; to train her mind to a wider outlook than that usually obtained within the four walls of an institution, bringing into line with the curative measures the no less important branches of preventative work - those branches securing the Nation's Health and well being through its mothers, its infant and child life, its racial inheritance, its economic and social state; so that a nurse at the conclusion of her general training may, with knowledge and some preparation make a free choice of her work life, and develop along any one of these allied branches (Still 1921, p.266).

The evolution of General Nursing.

The 1919 Nurses Act came into being just after WWI and at a time when the District General Hospital (DGH) provided accommodation for those with chronic illness and the elderly (Rivett 1998, p.5), with most hospital wards being dedicated to either General Medicine or General Surgery⁶. The SRN role at the time was very much about being versatile in terms of responding to the type of medical conditions on the ward, and being a 'generalist', because treatment was often based on good nursing care and the limited range of drugs available. As the nature of disease changed, combined with advances in medical knowledge, medical specialties evolved, for some SRNs this opened up opportunities for sub specialisation in the evolving technical wards and departments⁷. Specialization within the DGH brought with it unrest for many SRNs working on General wards regarding their poor working conditions, a situation explored by Athlone (HMSO 1939), who recommended the 'General Nurse' be relieved of doing non-nursing work through employing more hospital orderlies and maids, recommendations

⁶ although separate orthopaedic and infectious wards were common place.

⁷ Eg. the operating theatre, intensive care and renal units where they used technology supported medicine in the form of kidney dialysis, heart monitoring and ventilatory mechanisms.

criticized by the Royal College of Nursing (RCN) on the grounds they were not based on a proper study of the General Nurse role. The RCN responded with the Horder commission, which also recommended relieving hospital RNs of non nursing duties through employing ward clerks, catering services and trained housekeepers⁸ (RCN 1945).

Throughout WWII hospitals became depleted of Doctors as they were relocated to front line positions, as a consequence SRN's are repoted to have extended their roles through taking on additional skills⁹, one dimension of the role stretched to the limit at this time was 'supervision', brought about by recruitment of the Civil Nursing Reserve (Baly 1980). Up until the creation of the NHS the General Nurse was very much left to his / her own devices responding to Doctors' orders and local arrangements because hospitals varied considerably in terms of opportunities for the SRNs to develop their role. On creation of the NHS the Ministry of Health (MoH) suggested the Nursing profession should be free to develop and design their own training and create a college of nursing, but as White (1982, 1985) pointed out, both the RCN and the GNC failed to understand what was being offered to them and drew back from these proposals, resulting in the government for the second time¹⁰ taking control of nursing's future.

Because Horder had focused on the Student Nurse the Nuffield Provincial Hospital Trust pointed out the report's failure to answer the question 'What is the proper task of the [General] Nurse in hospital wards?', setting up their own study of the work of Nurses in hospital wards (Nuffield Provincial Hospital

⁸ Also recommending development of a General Nurse career structure whereby ward teaching, ward management and ward administration became equally important branches of the same tree, each with prospects for promotion as opposed to the existing ladder of promotion to hospital Matron (RCN 1945).

⁹ as to what these extended skills were remains a mystery as they are not reported specifically in the literature.

¹⁰ The first time being as a result of the squabbles regarding the registration of nurses.

Trust 1953¹¹), using the technique 'job analysis' to track the activities of all grades of hospital ward staff to reveal the total work of the ward, and the people undertaking this work, a much broader issue than the role of the SRN. The job analysis project team identified three types of hospital ward work: Nursing, Organizational and Domestic shown in figure 4, supplementing each with detailed descriptors shown in appendix 1.

Figure 4: Three types of work in a hospital ward (ibid., p.26).

1. **Nursing.**
 - a. Basic.
 - b. Technical.
2. **Administration and Organization.**
 - a. Maintaining contact with other hospital departments
 - b. Internal organisation of a ward.
3. **Domestic Duties.**
 - a. Heavy cleaning
 - b. Light cleaning

'Nursing work' was defined as 'care [patients] received from ward staff', the reason for this care was described as 'to satisfy patients' needs', with patient 'nursing' needs classified as: Physical, Medical and Social described in figure 5.

Figure 5: Hospital Patients Nursing Needs (ibid., p.27).

Physical Needs.

These are the same as for any individual outside the hospital. The same basic facilities have to be provided to secure physical well-being, comfort and prevention of infection. The main difference outside to inside the hospital is the patient is more helpless, and needs things done he would normally do himself. (So the term 'basic nursing' is used for nursing duties with their origin in meeting patients' physical needs).

Medical needs.

Technical nursing is the term for care given as a result of the disease from which he is suffering.

Social needs.

These are social and psychological, which have their origin in the fact an individual has to adjust to his changed circumstances.

¹¹ the term of reference: 'A complete job analysis of the work of the Nurse and other members of the health care team in order to obtain the necessary data so that an answer can be given to the fundamental question 'what is the proper task of the nurse' (ibid., p.9).

The job analysis articulated the first classification of nursing work in hospital wards into: Basic Nursing, 'the care required in the interests of the comfort and well being of the patient, irrespective of the disease from which he is suffering' (ibid., p.28), and Technical Nursing, 'the nursing tasks concerned with the treatment of disease from which the patient was suffering' (ibid., p.28), with the latter sub-classified into four groups of technical procedures dependent on the role of the Nurse in relation to the Doctor, listed in appendix 2.

Rivett's (1998) interpretation of the job analysis was that it demonstrated 'what was happening in hospital wards was not what people thought it was' (p.9), as a result of revealing half the Ward Sister's time, and one third of the Staff Nurses' time was occupied by ward organization, whilst Student Nurses delivered the lion's share of basic nursing, predominantly without supervision, and were often left in charge of a ward at night, and sometimes during the day. Additionally the Student Nurse received only seven minutes ward teaching per week, resulting in them learning their craft from one another. The report concluded the Student Nurse was a student in name only, due to their labour making up half the nursing workforce.

The report acknowledged the Ward Sisters' role to be particularly difficult, due to their responsibilities being threefold: care of patients, administration of a ward, and the training of Student Nurses. The advisory panel to the Nuffield Provincial Trust comments on the job analysis findings endorsed three major issues:

1. Nursing should be done by trained nurses, not merely supervised by them.
2. Basic nursing should not be delegated wholly to an auxiliary grade, although a second pair of hands is desirable.
3. Nursing skills should be conserved by the reallocation of many non-nursing tasks

Goddard, the Project Director then presented the findings as providing evidence that there were enough General Nurses employed in hospital wards, but stressed they were not used to the best advantage, due to the wasted hours

spent on moving screens, chaperoning doctors and on tasks not requiring the skill of a General Nurse, concluding the problem lay in the maldistribution of work in hospital wards. The job analysis also revealed the General Nurse role on registration was mainly administration¹², which led Dame Cockayne to respond in the first nursing mirror lecture

Without doubt we have produced a really good bedside nurse and our best in this regard is unassailable anywhere in the world... BUT bedside care is only one part of the nurse's function today...it is not generally understood how much administration falls to the nurse ... immediately on qualification a nurse may find herself in charge of a large number of auxiliaries (Cockayne 1959, p.vii).

Although criticised for its methods, Baly (1980) suggests the job analysis broke new grounds, 'the soil had been turned over' (p.230), but despite the findings being hotly debated, and few arguing with them, little was done to change the General Nurse situation. Of the time when the report was made public Rivett (1998) points out there were two possible lines of development for the General Nurse, they could become recognised as a technician through removing basic care from their role, or the SRN could insist basic and technical aspects of their role are indivisible, through adopting an holistic nursing labour process,

thus avoiding auxiliaries performing basic care which could result in them performing a bed bath but failing to notice the patients condition worsening (ibid., p.106).

The House of Lords considered the job analysis findings, recommending that nursing needed re-organizing; this was endorsed by the Standing Nurse Advisory Committee (SNAC) through implementation of a small number of experimental schemes where the hospital ward nursing labour force were reorganized into teams, replacing the time honored tradition of task allocation.

The 60's brought with it an increasingly complex hospital environment, requiring the General Nurse to manage very ill patients in need of sophisticated treatment and drugs. Hospitals responded by developing more intensive care

¹² because Student Nurses provided the majority of bedside and technical care.

departments, where the role of the SRN was very different to that on a general ward:

The role changed from personal aspects of nursing geared towards the provision of relief and comfort into a world of new technology and the rise of 'other' workers ... (Baly 1980, p.188).

For the SRN working on a general ward they were catering for a wide range of patient conditions and patient acuity and poor working conditions led many to relocate their careers in the new technical specialities, Baly (1980) explains

technical knowledge advanced with such rapidity each generation was stranded on the beach of its own insecurity, and insecurity breeds aggression ... one effect of insecurity is to specialize (p.231),

The increasingly stressful environment led Titmus (1968) to suggest

the generalist occupies a world of uncertainty and it is safer and easier to specialize than generalize, as specialisms increase, this creates problems of communication, as each new group carved out its career and status pattern so the organizational pattern and chain of command becomes more complicated (p.208).

Simultaneously new groups of hospital staff were employed, each with specific duties for catering, engineering, supplies and pharmacy. On hospital wards clerks and orderlies were employed [to save nursing time] leading to the General Nurse having more people to co-ordinate, with more time being spent on preparing duty rotas, managing sickness, annual leave and personnel issues (Baly 1980, p.231).

Nursing became an unappealing profession, government's response was to recruit overseas nurses, and lower the entry requirements for student nurse training, structural changes which led to hospital wards being manned by staff of varying educational levels. Revans (1964) studied the ward environment in the context of the health of hospital staff at this time, reporting hospitals to be 'cradled in anxiety' as a result of the General Nurse role being dominated by support and supervision of staff educationally unable to calculate medicines and lotions, which worried the General Nurse, compounded on the general anxiety associated with being in charge of a hospital ward.

The focus then changed to the role of the General Nurse as a manager in the Salmon review (HMSO 1963) which recommended three levels of nursing management: first line, middle and top management, each requiring specific preparation, recommendations accepted by the MoH and implemented in 1969. RNs could now develop their role from clinical care on hospital wards to non clinical nurse management positions¹³, developments which resulted in consultants noticing General Nurses were leaving hospital wards for promotion, leaving less experienced Nurses in charge (Rivett 1998, p.261).

Also in response to the hospital environment becoming more complex, the syllabus preparing the General Nurse was revised (GNC 1969) to include four statutory practical assessments conducted in hospital wards, changes which led to the Ward Sister becoming a GNC certified practical assessor¹⁴.

During the mid to late 70's ward based General Nurses began to establish their own identity by adopting Henderson's¹⁵ definition of nursing,

The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or it's recovery (or a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible (Henderson 1979. p.4).

which endorsed the SRN's authority on the maintenance of patients daily living activities¹⁶, and the Doctor the authority on diagnosis and treatment of

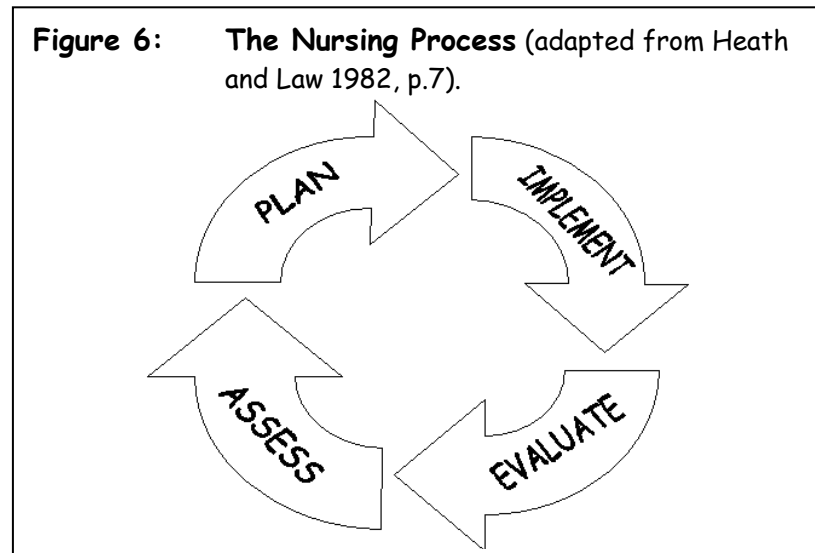
¹³ as opposed to the traditional nurse teacher or matron only career structure.

¹⁴ through completion of the GNC 'Art of Examining' course.

¹⁵ Originally published in 1955, recognized by the International Council for Nurses in 1960.

¹⁶ The Daily Activities of Living. The nurse helps the individual to: 1) breathe normally, 2) eat and drink adequately, 3) eliminate by all avenues of elimination, 4) move and maintain desirable posture (walking, sitting, lying and changing from one position to the other), 5) sleep and rest, 6) select suitable clothing, dress and undress, 7) maintain body temperature within normal range by adjusting clothing and modifying the environment, 8) keep the body clean and well groomed and protect the integument, 9) avoid dangers in the environment and avoid injuring others, 10) communicate with others in expressing emotions, needs, fears, or 'feelings', 11) worship according to his faith, 12) work at something that provides a sense of accomplishment, 13) play, or participate in various forms of recreation, 14) learn, discover, or satisfy the curiosity that leads to 'normal' development in health (Henderson, 1979. p.50),

disease¹⁷. Alongside adopting Henderson's philosophy of Nursing¹⁸, the 'Nursing Process' gained momentum where the SRN assessed, planned, implemented and evaluated each patient's care, depicted in figure 6.



Although this holistic approach to nursing was slow to be adopted throughout the profession, progressive approaches to deploying the nursing labour force becoming more widespread than the original experimental schemes in the form of Team Nursing and Patient allocation / assignment methods, as alternatives to task allocation, although in hospitals with less favourable ward staffing, and in crisis situations these often reverted back to job allocation.

The final factor in this era to impact on the General Nurse labour process evolved as a result of the Chief Nursing Officer (CNO), in her annual report pointing out the role of the nurse in relation to medical developments was affecting nursing practice,

High technology, the development of ICU and electronic monitoring placed new burdens on nurses' shoulders. There was little room in hospital for the ambulant patient. In a crisis nurses needed both to diagnose and to take action way outside the traditional nurses role, and in the process developed skills and knowledge in specialised fields

¹⁷ Rivett's (1998) view of the adoption of Henderson's model into a profession of nursing practitioners with differing values, led on one hand to some Nurses claiming autonomy over the labour process, whilst others in ITU and renal units were now substituting for Doctors (p.259).

¹⁸ Some refer to this as a MODEL of nursing.

beyond the competence of nurse management and not covered in student nurse training, becoming an integral part of medical teams (DHSS 1971).

The CNO admission led the RCN to send a delegation to the Secretary of State to point out the dissatisfaction within the profession as a result of Student Nurses being left in charge of frightening situations, situations beyond their competence due to the rising intensity of patient care, causing further Ward Sister anxiety, and a lowering of morale because General Nurses went off duty knowing their wards were inadequately covered. This RCN delegation is believed to have led to the setting up of a committee on nursing chaired by Professor Asa Briggs (Baly 1980)¹⁹.

The Briggs (HMSO 1972) tome opens with the statement 'the time is overdue for a radical review of the nursing situation' (p.2), and is nothing more than a survey of NHS hospital and community services, designed to demonstrate the current division in service provision did not work, against what was described as a backdrop of patient care moving towards treatment without hospital admission, and the discharging of patients from hospital earlier. A report which discussed possible changes to nurse education to meet future NHS needs, and culminating in numerous recommendations shown in appendix 3.

Briggs emphasized the importance of good management (ibid., section 53), indicating that 'crisis management' was due to a lack of forward planning and that 'every qualified nurse and midwife must in some sense be a manager and good management is a precondition of good care', pointing out Nurses continue to perform 'non nursing duties' and Nurses themselves felt elements of their work

¹⁹ with the following term of reference

to review the role of the Nurse and midwife in hospital and community and the education and training requirements for that role ... so that the best use made of available manpower to meet present needs and needs of an integrated health service. The concept of an INTEGRATED SERVICE being identified as what distinguished this report from others that had been commissioned over the last 40 years (ibid., p.v).

fell under this remit, the resultant effect being the widespread opinion that this was a waste of skills in Nursing ... (section 118)

This sense of waste persists despite the repeated efforts that have been made of recent years to reduce non-nursing duties to a minimum ... successive secretaries of state have emphasized the need to conserve precious nursing skills ... our surveys show that nurses and midwives themselves still see much room for improvement ... we do not ourselves wish to draw clear-cut distinctions between nursing and non- nursing or even 'semi nursing', to introduce a third category; and in certain circumstances what appear to be non-nursing or non-midwifery duties, like cleaning an isolation cubicle, will have to be performed by nurses or midwives (ibid., p.39).

In 1974 Chief Officers of existing Nurse training bodies met to discuss the report, these meetings broke down²⁰ resulting in the government in 1976 reaffirming their commitment to introduce legislation to implement the report's recommendations, and to change the statutory framework for Nurses into a single body. This took seven years to achieve because each time a bill reached the House of Commons a general election was called.

General Nurse education beyond registration.

In Braverman's terms, after completion of a craft apprenticeship, craftsmen entered journeyman structures to become master craftsmen. For the General Nurses their journeyman years were served largely delivering skilled care on the General Wards, continuing their learning 'on the job', because formal post registration educational opportunities were sparsely available, except for those in embedded surgical sub-specialities, and the increasing intensive care areas. Only small numbers of SRNs were able to access post registration education, causing many General Nurses to become dissatisfied regarding working or progressing their careers , many therefore chose to retrained as a Midwife or Community Nurse. Some of the specialist surgical courses available to the SRN are outlined in table 1.

²⁰ Squabbles ensued, and comparisons were made with the 1919 sectarian squabbles within the profession, which led to handing over control of nursing to the government.

Table 1: The evolution of specialist surgical nursing educational opportunities (adapted from Jolley and Darling 1982. pp.70-78).

| Date | Nursing Specialism | The association or specialist nursing group |
|--------|---------------------------|--|
| 1935 | Orthopaedic | Central Council for the Care of Cripples. British Orthopaedic Association and Royal Association for Disability and Rehabilitation. |
| 1950 | Otology | Midland Institute of Otology. Nursing diploma founded 1950. |
| 1952 | Ophthalmology | Ophthalmic Nursing Board. RN - Ophthalmic Nursing Diploma (OND). |
| 1960's | Intensive therapy nursing | 1968 RCN established first Intensive Care Nursing (ICN) group. |
| 1967 | Plastic surgery | British Association of Plastic Surgery Nurses. |

The first reference to the diversity of courses for General Nurses was made by Horder (RCN 1945), but it was not until SNAC in 1966 drew attention to their limited availability, and the unsatisfactory nature of many courses that the government agreed to a national body to co-ordinate post certificate Nurse education. In 1970 the Joint²¹ Board of Clinical Nursing Studies (JBCNS) came into being to provide courses for General Nurses to enable them to extend their knowledge and skill to function more effectively in specialised clinical areas²² (Gardener 1977), their initial survey revealed 350 post basic courses in 47 different specialties, which reflected the trend towards specialization, courses which were subsequently regulated as JBCNS long clinical courses.

In 1974 short 'statemented'²³ courses were introduced, and the JBCNS' remit was extended to include community nurses. The most widely available post

²¹ **Joint:** the term joint according to Gardener (1977) in the boards title emphasised the co-operative nature of the enterprise set up by the Secretary of State with representatives from nursing, midwifery, the medical profession, central health department and health authorities.

²³ **Statemented Course:** Approved by the JBCNS which following attendance the Nurse was issued with a statement of attendance certificate, for example the 1975 first care of the dying short course.

registration course throughout this era remained the GNC 'Art of Examining' for Ward Sisters and Sister Tutors, to enable them to discharge the 1969 statutory requirements for SRN practical examinations.

Concern regarding 'overlapping' roles.

The General Nurse role was brought sharply into the limelight in the Briggs Report in the section marked 'overlapping functions between Nurses and Doctors' (HMSO 1972. Section 140-143), which drew attention to the fact that differences in function between Doctors and Nurses were becoming less distinguishable. Briggs outlined the relative responsibilities of Doctors and Nurses, concluding there were no apparent legal objections to continuing the existing practice of dividing work between the two professions.

In 1974 a DHSS Joint working party was established to respond to 'overlapping functions' raised in the Briggs report, and to address concerns expressed by the medical and nursing professions regarding the extending role of the General Nurse. The working party issued a Health Circular (DHSS 1977) reporting they had conducted 'a small fact finding survey of tasks currently undertaken by nurses which appeared to represent an extension of the nurses' traditional role' concluding;

Increasingly nurses are involved in tasks, procedures and decision making which in the past has been a medical responsibility. This trend has caused some uncertainty about the legal implications and training requirements therefore the department has been urged to issue guidelines on the matter (p.2).

The end of an era:

Era 1 spanned 58 years during which the General Nurse was able to develop his / her role based on clinical experience and medical specialization, this freedom to develop ended on issuing of the extending role Health Circular (DHSS 1977), which brought into being structural constraints on the role of the General Nurse.

ERA 2: From 'General Nurse' role restriction to RGN professionalization.

The extending role Health Circular (DHSS 1977) marked the beginning of a 15 year era of constraints imposed on the General Nurse's role development as a result of the statement

any extension to the (RN's) role could only take place in certain circumstances and must be based on medical delegation and certification (p.2).

Despite this edict the nursing profession balanced these restraints with its own agenda for professionalization. Proposals made in the Briggs report were brought into statute through the 1979 Nurses, Midwives and Health Visitor Act with which came a single regulatory body, the United Kingdom Central Council (UKCC) and four national boards for education, replacing a range of bodies responsible for nursing and midwifery education and registration²⁴. The first UKCC register comprised 11 parts, with the SRN / General Nurse re-named the Registered General Nurse (RGN) shown in table 2.

Table 2: The UKCC (1991) 11 part professional register.

| Part of the register | New title | Previous title |
|----------------------|---|----------------|
| Part 1 | Registered General Nurse | SRN / RGN |
| Part 2 | Enrolled Nurse: General | SEN |
| Part 3 | Registered Mental Nurse | RMN |
| Part 4 | Enrolled Nurse: Mental | SEN(M) |
| Part 5 | Registered Nurse for the Mentally Handicapped | RNMS/RNMD |
| Part 6 | Enrolled Nurse: Mental Handicap | SEN(MH) |
| Part 7 | Registered Sick Childrens Nurse | RSCN |
| Part 8 | Registered Fever Nurse (opened to admit those possessing this registration but then immediately closed) | |
| Part 9 | Enrolled Nurse (previously EN in Scotland and northern Ireland) | |
| Part 10 | Registered Midwife | SCM |
| Part 11 | Registered Health Visitor | |

²⁴ **UKCC (July 1983) Replacement of existing bodies:** General Nursing Council (GNC), Central Midwives Board (CMB), Queens institute for District Nurses, School Nursing Association, Health Visiting Association (HVA). Industrial Nursing.

The 'extending' role mandate.

The Chief Medical Officer [CMO] letter accompanying the extending role circular opened with the statement

The role of the nurse is continually developing, and nurses are constantly acquiring new skills to meet new needs ... extension can be in several ways; by development within the traditional role, in response to emergencies and by delegation from doctors. However, it is where the nurse's role is extended by delegation that there is a need for clarification ... the attached health circular spells out the circumstances in which delegation can properly take place (DHSS 1977a. section 1:1).

The RN role was defined on two levels (DHSS 1977b), a 'Basic' role, prepared for during training and an 'Extending' role, which evolves through continuing practice and training, adding new functions to the normal range of nursing duties. Anything beyond these two role levels in relation to the role of the Doctor was stated to be an 'extended' role, stipulating this could only occur by delegation from a Doctor or in response to an emergency. The four circumstances under which Doctors could delegate to Nurses were

- a) The nurse has been specifically and adequately trained for the performance of the new task and she agrees to undertake it;
- b) This training has been recognised as satisfactory by the employing authority;
- c) The new task has been recognised by the professions and by the employing authority as a task which may be properly delegated to a Nurse;
- d) The delegated doctor has been assured of the competence of the individual nurse concerned (DHSS, 1977, p.2).

The RCN and BMA responded to the extending role circular in a joint statement;

[we are] anxious to ensure that the nurse's primary task of giving personal nursing care, support and understanding to the patient or client and his/her family, should not suffer from pressure of other work, and furthermore, that the nurse's position is safeguarded when he/she is called upon to undertake tasks outside the routine scope of nursing (RCN, 1978, p.2).

followed by the RCN reinforcing its standpoint (RCN 1979) that listing extended roles limited nursing, because RNs had already extended their role in many different ways and as an independent profession nurses should have the freedom to plan care, indicating the 'extending' role Health Circular reduced the role of the nurse to task orientation and job labelling (p.3). The RCN concluded,

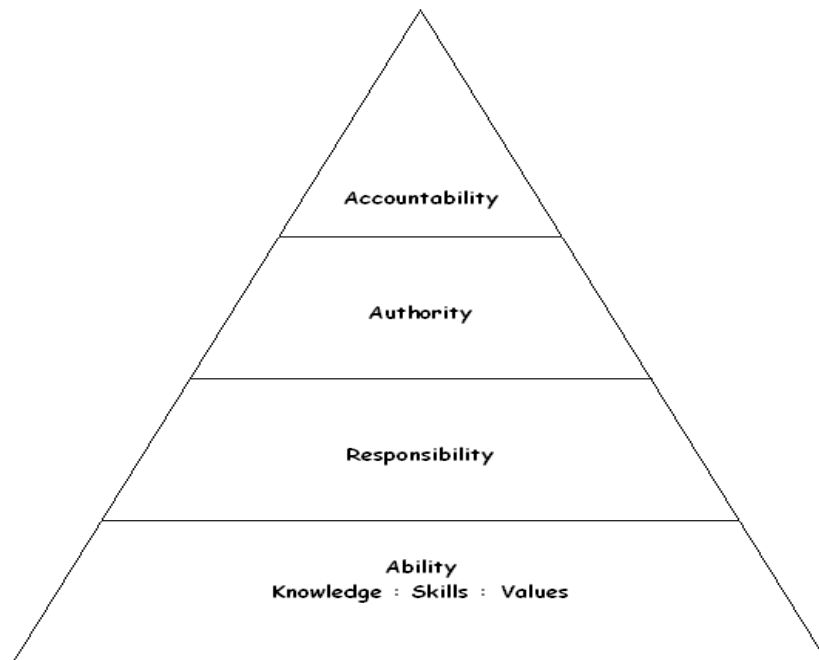
two practical issues surrounded Nurses role development needed to be considered: first was the need for the development of employment policies to ensure RNs had indemnity insurance through vicarious liability, and second they asked Nurse Educators to consider how basic RN training could address some of these issues. The response from Nurse Educators was to reiterate the only procedures General Nurses were taught, were those in the GNC syllabus.

'General Nurse' professionalization.

One of the UKCC's first initiatives was the issuing of a Rules Approval Order (UKCC 1982) replacing the GNC General Nurse syllabus with a set of first level Nurse competencies referred to as Rule 18(1). Rule 18(1) changes meant future General Nurses were prepared on a firm footing of nursing theory and practice in the form of the nursing process and nursing models, with new competencies expanding the statutory nursing remit into health promotion and illness prevention, the future General Nurse labour force in Braverman terms were being prepared for a role which comprised a unity of conception and execution, where on graduation RGNs had control over the hospital patient production process, as opposed to being trained in the previous era on what some refer to as the medical model, enabling them to be handmaidens to the medical profession.

The UKCC re-structuring of General student education led to widespread restructuring of the hospital nursing labour process, building on previous experimental schemes which replaced task allocation with more progressive Team and Primary Nursing care organization systems. In Braverman terms modernization of the nursing labour force led to widescale autonomy over the production process, with which came accountability for the decisions made in the course of the RN's work and for delegation of work to nursing assistants. Thus true nursing accountability was achieved because in Bergman's (1981) view the pre-conditions to being accountable were structurally in operation for the General Nurse, depicted in figure 7.

Figure 7: Model of the pre-conditions leading to accountability (Bergman 1981, p.55).



As the RGN's role became more holistic, the drive for this to be recognised gained momentum, in the form of challenging the term 'task' in the extending role circular. Government responded by setting up a working party to review the extending role guidelines, concluding the term task was inappropriate in the current climate (SNAC/SNMAC 1986), the term task was changed to 'activities'²⁵, with these restated as three categories:

1. Activities for which Nurses are prepared in the course of their pre registration training
2. Those more specialized activities for which Nurses are prepared by post registration training
3. Activities normally undertaken by doctors but may be delegated in appropriate circumstances and which may be performed by Nurses with appropriate training and competence (this 3rd category became the extended role).

The UKCC then turned to future student nurse preparation through issuing their proposed Project 2000 strategy (UKCC 1986)²⁶, through announcing a three fold

²⁵ stating the former implied task orientation which was not to be encouraged, because nurses are concerned with the whole person.

²⁶ with the student nurse curriculum being broader, health based and more community oriented (MacLeod Clark and Maben 1998).

division of the nursing labour force: a single level RN²⁷, a more advanced/specialist grade for RNs in the community and a new support worker.

The focus then turned to post registration nurse education (PREP) and resurgence of the Generalist and Specialist Nurse debates, originally raised in Project Paper 5 (UKCC 1985a)²⁸. The initial PREP report (UKCC 1990) recommended: continuation of practice as an RN was to be based on being up to date, the RN was to be a formal supervisor of new RNs²⁹, there would be an opportunity to define specialist / advanced practice, and a new career structure.

Re-structuring the 'General Nurse' labour force: The government agenda.

In May 1988 the new Conservative Government announced acceptance of Project 2000, replacing 69 years of 'General' Nurse apprenticeships with HE prepared Adult RNs. Structural changes to the preparation of future RNs caveated with two stipulations for the Nursing profession: widening of the entry requirements for nurse training, and the acceptance of a new support worker prepared under a national training framework. Enter Braverman's impetus for concern, the introduction of the concept 'new' in the occupational market, in this case the new Adult Nurse and their new support worker. Swiftly following this change in Nursing the government implemented the white paper Working for Patients (HMSO 1989) introducing into the NHS the internal market. District General Hospitals (DGH) became Acute Trusts and General Practitioners fundholders, marking the beginning of shifting the balance of power away from provider units to purchasers. The future role of the RN in the re-structured NHS was set out in the 'Strategy for Nursing' (DOH 1989)³⁰, in which four areas for future nurse

²⁷ as a result of the phasing out of the second level Enrolled Nurse.

²⁸ Redrawing the boundaries (UKCC 1985a) which resulted in the setting up of a project to develop a framework for Post Registration Education and Practice (PREP).

²⁹ due to their broader, health based preparation.

³⁰ in the preface to which Kenneth Clarke pointed out

the government's momentous achievements regarding nursing over their two years in office through agreeing to Project 2000 and a new career structure, were two

development were outlined: Practice, Manpower, Education and Leadership / Management, each with set targets regarding the RN's future role, shown in appendix 4.

Launch of the 'Strategy for Nursing' opened the floodgates for the lens to focus on the acute trust nursing labour force from many directions. First by the King's Fund Institute (Beardshaw and Robinson 1990) who proposed a number of challenges for RGNs including nurse led health care provision, re-assessment of skill mix and the potential for substitutions across traditional health service job demarcations. The King's Fund report concluded there was a need to improve the calibre of untrained staff, and a new management approach hailed as

a critical determinant of the extent to which nursing's Victorian legacy of uncritical obedience, hierarchy and the undervaluing of nursing work can finally be laid to rest (p.41).

The Audit Commission (1991³¹) singled out hospital RNs in improving patient care in three major areas: 1) becoming more quality conscious and patient centred, 2) ensuring continuity of care, and 3) improving skill mix, outlined in more detail in Appendix 5. Other reports explored different ways of providing hospital services, particularly Day Surgery (NHSME 1991a) and Out Patient care (HMSO 1991), with the King's Fund Institute (1991) emphasising the role of RGN in discharging patients from hospital. Collectively these reports suggested there was scope for developing the RN's role into new areas of hospital work, selling their proposals to the nursing profession as 'a quality of care agenda'.

The Ward Sister was seen as pivotal to achieving these changes, so to support their role a management training programme was launched in the form of the 'Rainbow Pack' (Greenhalgh and Company 1991), training which oiled the wheels for a major change to the role of the Ward Sister in terms of managerial

significant steps forward for the nursing profession which demanded changes in attitude and thinking by the nursing profession (DOH 1989, p.2).

³¹ The report was titled: 'How to best use the nursing resource to improve the quality of patient care'.

responsibility for workload, skill mix and ward finances. Content of the training is outlined in figure 8.

Figure 8: Using information in managing the nursing resource: The Rainbow Pack (Greenhalgh and Company 1991).

- Setting the context
- Analysis and presentation
- Workload
- Skill mix management
- Human resource management
- Quality
- Financial management

Continuing the quality agenda government launched The Patients' Charter (DOH 1991), in which it contained a standard 'you should have a named qualified nurse responsible for your care', reiterating a statement from the Strategy for Nursing (DOH 1989). Launch of the concept 'Named Nurse' led to uncertainty in the Nursing profession as to what exactly this meant, and how it was to be applied. William Waldegrove responded to these concerns stating the Named Nurse was not synonymous with Primary Nursing³².

Divergent discourses evolved as to whether the Named Nurse was a politically or professionally driven initiative, with the optimists believing it meant official approval and extra funding for the widespread introduction of Primary Nursing (Hancock 1992), whilst the pessimists saw it as no more than a cosmetic exercise, or at worst a backdoor means of saddling nursing staff with tasks Junior Doctors no longer wished to perform (Cole and Davidson 1992).

The end of an era.

After many years of Junior Doctor campaigning for an improvement in their working conditions their voice was truly heard when government published seven

³² but involved a named Nurse, Midwife or Health Visitor being responsible for planning, monitoring and implementation of each patient's care (Cole and Davidson 1994, p.24).

'New Deal' papers (NHSME 1991b). Paper six³³ requested a review of local policy concerning which tasks appropriately qualified nurses and midwives could reasonably undertake (ibid., paper 6 point 1) urging General Managers, in consultation with medical and nursing colleagues to consider the scope for extending local policies and procedures relating to duties conventionally undertaken by medical staff (paper 6 point 5). Launch of the New Deal led to the setting up of regional task forces to investigate the interface between RN's and Junior Doctors. Simultaneously the BMA commissioned the consulting group Greenhalgh and Company to study the issue in more detail. Because Junior Doctors work exclusively in acute hospital wards following leaving university, the BMA commissioned report focused its lens on the Hospital RN.

This era drew to a close when the DOH (1992) issued PL/CNO(92)4, which stated the extending role circular was withdrawn, and the terms 'extended' or 'extending' role in relation to the RN were no longer favored, as they limit rather than extend the parameters of practice.

ERA 3: The demise of the 'General Nurse' (RGN) and medical substitution.

This era spans a solitary decade, it commenced with a nursing agenda and ended with a governmental one. At the start of the decade the UKCC issued to all its registrants the Scope of Professional Practice (UKCC 1992a), emphasising RN accountability for their role development. Structural changes theoretically legitimising RNs to develop their role serving the interest of patients, as opposed to tasks being delegated by medical staff, principles signalling a move towards RNs regulating their own practice through being responsible for their own competence instead of certification from another professional group. The UKCC (1992a) scope document provided six principles for RN role expansion listed in figure 9.

³³ Titled: Making the best use of the skills of nurses and midwives.

Figure 9: The Scope of Professional Practice principles (UKCC 1992a. p.6).

1. Must be satisfied that each aspect of practice is **directed to meeting the needs** and serving the interests of the patient or client;
2. Must endeavor always to **achieve, maintain and develop knowledge, skill and competence** to respond to those needs and interest;
3. Must honestly acknowledge any **limits of personal knowledge and skill** and take steps to remedy any relevant deficits in order effectively and appropriately to meet the needs of patients and clients;
4. Must ensure that any enlargement or adjustment of the scope of personal, professional practice must be achieved **without compromising or fragmenting existing aspects of professional practice** and care, and that the requirements of the Council's Code of professional Conduct are satisfied throughout the whole area of practice;
5. Must recognize and honor the direct or indirect **personal accountability** borne for all aspects of professional practice;
6. Must, in **serving the interests of patients and clients** and the wider interests of society, avoid any inappropriate delegation to others which would compromise those interests.

As the newly implemented three year Adult Nurse preparation was completing its first cohorts, and General Nurse apprenticeships were coming to an end, to accommodate the new Adult Nurses the UKCC issued a 15 part register shown in Table 3. 'Old' trained General Nurses, prepared under the apprenticeship system

Table 3: UKCC (1994) 15 part register.

| Part of register | Description. * 'Project 2000' prepared RN's. |
|------------------|---|
| Part 1 | First level nurses - general nursing |
| Part 2 | Second level nurses - general nursing (England and Wales) |
| Part 3 | First level nurses - mental illness |
| Part 4 | Second level nurses - mental illness (England and Wales) |
| Part 5 | First level nurses - mental handicap |
| Part 6 | Second level nurses - mental handicap (England and Wales) |
| Part 7 | Second level nurses (Scotland and Northern Ireland) |
| Part 8 | Nurses trained in the nursing of sick children |
| Part 9 | Nurses trained in the nursing of persons suffering from fever |
| Part 10 | Midwives |
| Part 11 | Health Visitors |
| Part 12 | Nurses - adult nursing* |
| Part 13 | Nurses - mental health nursing* |
| Part 14 | Nurses - mental handicap nursing* |
| Part 15 | Nurses - children's nursing* |

registered on Part I, whilst the 'New' Adult Nurse registered on Part 12.

RN Scope or Medical Substitution ?

UKCC registrants having been granted autonomy over their role as a result of their governing body issuing the Scope of Professional Practice (UKCC 1992) found the euphoria associated with this landmark to be short lived, due to it being overshadowed by the BMA task force report on the interface between Junior Doctors and Nurses (Greenhalgh and Company 1994), and the only study since the Nuffield Goddard job analysis to comprehensively explore the role of the RN within Acute Trust [surgical] wards.

The Greenhalgh study was no more than what Braverman describes as a Taylorian scientific management exercise, commissioned by a vested interest group³⁴. The study commenced with a review of published literature, from which 32 activities were identified, listed in appendix 6; these were then reported as the most commonly shared activities between Junior Doctors and Nurses, and the activities Junior Doctors were asked about regarding their role. Unsurprisingly Junior Doctors revealed they felt 'frequently' used as: a porter, a bed manager, a rewriter of drug charts, a skivvy regarding the taking of bloods, a filler in of forms and 'frequently' beeped inappropriately. Of the 32 activities, eight were identified as occupying most Junior Doctor time, listed in table 4, and reported to offer the greatest potential for saving Junior

Table 4: The eight activities taking up most Junior Doctors time (Greenhalgh and company 1994).

| Number | Activity |
|--------|--|
| 32 | Taking a patient history including a full physical examination |
| 9 | Venous blood sampling |
| 7 | Peripheral venous cannulation |
| 21 | Referring a patient for investigation |
| 20 | Urethral catheterisation |
| 29 | Writing and signing discharge and transfer letters to GPs etc |
| 11 | Attend cardiac arrest |
| 4 | Administration of IV drugs (excluding cytotoxic and 1 st dose) peripherally |

³⁴ Commissioned by the BMA and the same consulting group who previously issued the Rainbow Pack.

Doctor time, with one exception, the 'taking of a patient history', because it included physical examination it was singled out as an activity Junior Doctors still need to undertake, although suggestions were made time could be saved if RNs gathered some data and stored it in a joint patient record.

The study concluded suitably trained RNs could share in at least 7 of the 8 activities, but indicated the amount of Junior Doctor time saved by implementing this would be unlikely to make an impact on their hours of work or rostering, but would alleviate pressure on them and 'may contribute to an improvement in their quality of life' (ibid., p.103). Greenhalgh concluded 29 activities had the potential for RN participation³⁵, and proposed two approaches to sharing activities at night: 1) through employing Night Practitioners trained and experienced in activities only operating at night, 2) the training up of existing Night Sisters to perform these activities, two solutions which would guarantee a reduction in the number of calls to the on call doctor, thereby ensuring they obtained better rest. Six activities were singled out to be 'shared by Junior Doctors not merely transferred to RNs' shown in Figure 10, and the report culminated in 23

Figure 10: The six activities (Greenhalgh and Company 1994).

- 1) The taking of a patient history.
- 2) Venous blood sampling.
- 3) Insertion of peripheral cannulae.
- 4) Referring a patient for investigation.
- 5) Writing discharge letters to General Practitioners and Doctors.
- 6) Administration of IV drugs (excluding cytotoxic and first doses) via peripheral cannulae.

recommendations, listed in appendix 7. Recommendations described by the authors as 'to contribute to improvement in patient care, enhance the role of the nurse and reduce the inappropriate workload of junior doctors' (ibid., p108), with

³⁵ caveated with the statement RN's were already trained and undertaking these on many occasions.

the final executive statement reporting these developments would improve the working lives of Junior Doctors, no reference was made to the effect of transferring / sharing these tasks on the working lives of RNs in acute wards. Following the UKCC scope announcement and the Greenhalgh report there evolved mass up-skilling of RNs in the hospital in three particular tasks Junior Doctors no longer wished to perform; venous blood sampling (Campbell 1995; Inwood 1996), Intravenous drug administration (Grundy 1996; McConnell 1996; Konick-McMahon 1996), and peripheral venous cannulation (Castledine 1996; Dougherty 1996; Jackson 1997; Gray 1997).

Mixed views evolved regarding the scope of practice agenda from both the nursing and medical professions. Wright (1995) cautioning RNs regarding further expanded activities until certain critical questions were answered, listed in figure 11.

Figure 11: Questions regarding role expansion (Wright 1995, p.28).

- Will patient care get better?,
- Will this new work help make care more patient centred, holistic and coordinated ?
- Will core nursing be preserved ?
- Are the essential values and practices associated with caring protected ?
- Is the nurse competent to do the task?
- Is the nurse able to judge?
- Is there management support?
- Is education available ?

Wright's final question being

Are we clear about our motives ? Are we trying to meet expedient service needs under duress or threat, to seek higher status or professional aggrandizement, or to improve patient care ? (ibid., p.29).

A Scottish survey on the effects of the introduction of 'scope' (SODOH 1995) reported benefits to patients, nurses, medical staff and the organization, outlined in appendix 8, but also raised a set of drawbacks listed in Figure 12.

Figure 12: The real and potential drawbacks of new roles for RNs (SODOH 1996. p.39).

- Potential de-skilling of others eg other nurses and junior doctors.
- Potential role ambiguity.
- Potential difficulty in work prioritisation with a concern that traditional nursing duties would be relegated in favour of new skills.
- Potential confusion over responsibility.
- Some junior medical staff had / or might abdicate responsibility for shared roles
- Confusion over titles being used for new roles.
- Concern that nursing will become fragmented and task based.
- Difficulties in trying to incorporate new roles into present resources.
- Training costly and time consuming.
- Lack of support for nurses in new roles.
- Emotionally draining, stressful and isolating nature of new roles.
- Increased risk and potential for litigation.
- Concern over what will happen to new nursing roles if medical manpower levels increase ie whether doctors would try to exclusively regain some skills now being undertaken by Nurses.

Medical discourse expressed mixed views on 'Scope', Consultants issuing a statement strongly advising the continuation of previous cautious delegation principles (JCC 1996), whilst up and coming medics chose to research evolving hospital Nurse Practitioner roles (Dowling, Barratt and West 1995), demonstrating they were in favour of the moves to more nursing autonomy, yet one year later cautioned confusion regarding accountability (Dowling et al 1996).

Nurses' governing body was also keen to demonstrate how 'Scope' was working in practice, through issuing to all registrants publications (UKCC 1997a; 2000a) illustrating case studies of RNs taking on new roles³⁶. The true extent of Junior Doctors' feelings regarding activities they were expected to perform in hospital wards was revealed in a BMA (1997) report of 2nd year medical graduates,

³⁶ At the same time an RN was publicly scapegoated for allegedly undertaking an appendectomy (Peysner 1995).

findings pointed out to the nursing profession by the editor of the British Journal of Nursing

Junior Doctors' time is dominated too much by low-level repetitive tasks such as taking bloods and inserting venflons which could be eased by transferring these tasks to other hospital staff (Scott 1997, p.300).

New educational frameworks for RN development.

RN 'scope' and debates regarding task substitution soon paled into the background when the UKCC and English National Board (ENB) separately launched their vision for the co-ordination of post registration nurse education. The ENB was first into print, with their Framework and Higher Award (ENB 1991)³⁷, based on 10 Key Characteristics of nursing practice listed in Figure 13, each characteristic accompanied by a set of learning outcomes shown in appendix 9.

Figure 13: The 10 Key Characteristics of nursing practice (ENB 1991).

1. **Exercise professional accountability**
2. **Specialist skills, knowledge and expertise**
3. **Ability to use research**
4. **Team working**
5. **Flexible and innovative approaches to ...**
6. **Health promotion and preventative policies and strategies.**
7. **Assess the professional and other development**
8. **Allocation of resources**
9. **Evaluate quality of care**
10. **Manage and evaluate change.**

Launch of the ENB Higher Award led to its implementation throughout England at a time when hospital based Schools of Nursing were forging links with HEIs, a policy change which led to the Higher Award being a jointly validated professional and HE award, with existing Post Registration clinical courses for acute hospital RNs accredited at diploma and later degree level. Developments which resulted in a nationwide, co-ordinated framework being embedded for RNs what Braverman described as structures whereby the apprentice graduate

³⁷ The ENB Higher Award was available for all RNs (and Midwives) but the majority uptake was by hospital RNs because community practitioners were already prepared to degree level.

can access in their journeyman years opportunities to facilitate their becoming master craftsmen, in this case specialist hospital based RNs.

Hospital RNs were able to access specialist clinical courses recordable on the UKCC Register. Uptake of these reached an all-time high in the mid to late 90's. The benefits of the ENB framework were acknowledged in the profession (Crotty et al. 1993) as creating a true partnership between the practitioner undertaking the programme, the academic provider and the patient in the hospital, achieved because everyone had subscribed to an ethos

For the first time in a national programme, we considered that the academic value of practice was acknowledged and credited, and learning at diploma and degree level are required to be demonstrated and integrated into practice (p.47).

For hospital RNs the ENB framework provided an opportunity for true professionalization, the new structures enabled clinical role advancement through clinical courses HE validated for RNs following registration, characterised here as the human capital expansion era for hospital RNs.

The UKCC then launched their Post Registration Nursing Education and Practice [PREP] (UKCC 1993) framework, which proposed three levels of nursing practice; Primary, Specialist and Advanced. Within the 'specialist' category three areas were identified; Critical, Acute and Continuing Care Nursing defined in Figure 14, supplemented with the first UK classification of nursing sub-specialisms shown in Table 5.

Figure 14: Descriptors of the three areas of specialist nursing practice (UKCC 1993).

Critical care nursing is concerned with crisis intervention and restoring and maintaining balance when physical or mental health is compromised to a life threatening degree.

Acute care nursing intervention is concerned with sustaining through crisis - or planned intervention - which compromises health to a potentially serious degree.

Continuing care nursing intervention is concerned with the promotion of health, well-being and independence and/or maintaining support, including rehabilitation over time.

Table 5: The Council's three areas of specialist practice (UKCC 1993).

| Area of specialist practice | Specified specialisms |
|------------------------------------|---|
| Critical Care Nursing | Accident and emergency nursing |
| | Burns and plastic surgery nursing |
| | Cardio-thoracic nursing |
| | Coronary care nursing |
| | Facio-maxillary nursing |
| | Intensive care nursing |
| | Neuro-medical or neuro-surgical nursing |
| | Organ or tissue transplantation nursing |
| | Neonatal intensive care nursing |
| Acute Care Nursing | Anaesthetic nursing |
| | Child and adolescent psychiatric nursing |
| | Drug, alcohol and other substance abuse nursing |
| | Ear, nose and throat nursing |
| | Genito-Urinary nursing |
| | Gynaecological Nursing |
| | Medical Nursing |
| | Controlled environment nursing |
| | Operating theatre nursing |
| | Ophthalmic nursing |
| | Orthopaedic nursing |
| | Renal and Urological nursing |
| | Rheumatological Nursing |
| | Surgical Nursing |
| Continuing Care Nursing | AIDS and HIV nursing |
| | Behavioural modification nursing |
| | Behavioural psychotherapy nursing |
| | Child protection nursing |
| | Dementia nursing |
| | Dermatological nursing |
| | Infection control nursing |
| | Nursing the dying |
| | Nursing the elderly |
| | Oncology nursing |
| | Palliative care nursing |
| | Physical disabilities nursing |
| | Rehabilitation nursing |
| | Spinal injuries nursing |
| | Stoma care nursing |
| | Family planning nursing |

One year later the final UKCC (1994) PREP position statement omitted the specialist nursing practice areas, their justification being that these would be addressed at a later date.

some [specialist nursing practice] areas need to go forward, but not all, indicating the UKCC would determine these at a later date, except for Specialist 'COMMUNITY' health care practice which would be available and recordable from December 1994 in eight areas (UKCC 1994).

Eight specialist practice areas were placed on statute from April 1995, shown in figure 15, signifying to hospital RNs 'Community' Nursing was to be dominant in the government's future NHS agenda.

Figure 15: Eight recordable areas of specialist nursing practice (UKCC 1994).

- General Practice Nursing
- Community mental health
- Community Mental Handicap
- Community childrens
- Public Health Nursing (Health Visiting)
- Occupational Health
- Nursing in the home (District Nursing)
- School Nursing.

Clearly the UKCC and ENB were focusing on different areas of post registration nurse education, the UKCC on Community Nursing, and the ENB on hospital nursing. Community Nurse roles and preparation gained prestige as a result of the 1997 Nursing, Midwifery and Health Visitor Act indicating their 'Specialist' practitioner status, followed by the issuing of standards for specialist education and practice for community nurses (UKCC 1998a), whether an oversight or a purposeful act, there was no mention of Hospital RN post registration education or formal career development as specialist practitioners.

One additional burden on the already busy and multidimensional role of the hospital RN which gained momentum at this time was that of being a 'clinical supervisor', a role originally mentioned in the Strategy for Nursing. This role became endorsed by the UKCC (1996) when they issued guidelines to registrants, opening the floodgates for RNs to be involved in Clinical Supervision (RCN 1999) and Trusts to develop strategies to enable the implementation of clinical supervision.

The Conservative Government approach to risk and reform.

On the backdrop of accepting Project 2000 and introduction of the internal market John Major launched a cascade of reports focusing on improving hospital services (Audit Commission 1992a; Kings Fund Institute 1992). 'A Vision for the future' [of Nursing] (DOH 1993a) was then launched, which Virginia Bottomly indicated was building on the previous government's Strategy for Nursing:

The future imperative for nursing, midwifery and health visiting must be to work in partnership with other professionals, users of services and carers. This participation will improve the general health and life expectancy of the whole population ... the end result of these new initiatives will be an understanding of each individual, and a desire to participate with them in their health care in a way that preserves their dignity (ibid., p.v).

Five ways were identified as to how RNs could achieve the 'vision' shown in figure 16, with twelve targets set for the Nursing profession focusing on the RN's role in quality, audit, accountability, clinical leadership, research, supervision and education shown in appendix 10.

Figure 16: Five ways to achieve the vision for the future (DOH 1993a, p.v-ii).

1. **Quality, Outcomes and Audit:** To provide care on an individual basis, with the outcomes charted and the delivery submitted to audit.
2. **Accountability for practice:** To develop an awareness of the duties and obligations connected with individual professional accountability.
3. **Clinical and professional leadership, clinical research and supervision:** To develop clinical and professional leadership in a corporate management agenda.
4. **Purchasing and commissioning:** To consider how clinical and professional expertise might feed into the commissioning and purchasing cycle.
5. **Education and professional development:** To ensure that the educational and personal development needs of practitioners are met in order for them to deliver high quality care.

The DOH then hosted a series of seminars, culminating in publication of the Heathrow debate (DOH 1993b) outlining the challenges for nursing regarding:

care teams, nurses' role, co-operation with other professionals, accountability, quality and training³⁸. All then seemed rosy regarding Nursing's future because it appeared to be on a firm footing of improving quality through the Strategy for Nursing (DOH 1989), the patients' charter named nurse (DOH 1991) and the vision for the future (DOH 1993a).

Serious failures then came to light in NHS hospitals, causing government to re-focus their lens from development of the RN's role in quality care for hospital patients to defensive risk management. Every NHS ward and department was issued with 'Risk Management in the NHS' (NHSME 1996), a document containing a chapter dedicated to 'risks arising from working beyond one's competence', which stated ...

patients or clients and purchasers of health care are entitled to expect that the staff employed to carry out health care will be competent to practice (ibid., p.28).

Staff competence was identified as compromised when those newly appointed into positions are inexperienced in an area of practice³⁹, pointing out patients reasonably expect to receive care from competent staff, staff who can expect training, advice, support and supervision to do their job. The final recommendation for good risk management practice in the NHS was 'always having sufficient qualified staff available to give supervision, advice and support to less experienced staff⁴⁰, because of the potential for an untoward incident occurring' (ibid. p.29)⁴¹, with the provision of patient care outside of the

³⁸ A year later the DOH (1994) issued the statement of strategic intent outlining fundamental principles regarding the education and training of Nurses and patient focused / practice led care, few in the profession chose to reply to this .

³⁹ stressing inexperience was no defense to an allegation of negligence, quoting the Wilsher v Essex Area Authority case.

⁴⁰ indicating failure to provide this access could place staff in a very vulnerable position, and may be considered to present unacceptable risks to patients or clients being treated. Particular concern was identified at night in the hospital, where the study revealed it was common for a D grade enrolled nurse to be left in charge, on a regular basis and in contravention of the nationally agreed terms on grading criteria., leaving the hospital open to considerable risk.

⁴¹ Culminating in three action points for NHS managers 1) newly appointed staff receive suitable training for their post at a suitably recent date 2) to ensure staff are trained, and 3) there

speciality identified as a particular risk⁴², as a result of the RN being faced with caring for patients in a specialty in which they do not normally practise, and with highly dependent patients they are not used to caring for. These risks were described as arising when nursing staff do not receive specific instructions or training regarding any specialist nursing care that may be required, indicating these risks are inherent when asking staff to carry out duties to which they are not accustomed, recommending this situation should be considered by managers and appropriate action taken to reduce the risks.

RN education by now was integrated into HE, and the voice for many RNs became the Council of Deans (1998), their response to government debates on the NHS was to support a more radical reform of nursing, proposing an all graduate profession with a rewarding clinical career structure organised around regional workforce plans for England, recommendations shown in figure 17.

Figure 17: Breaking the Boundaries (Council of Deans 1998).

- Statutory regulation, supervision and education of Health Care Assistants.
- The encouragement of Lifelong Learning.
- In the main Nurses are prepared to work in hospitals although government policy puts the focus on primary care.
- There are problems of contracting for education where staff are developing clinical academic careers and research.
- Council supports a single regulatory body for professionals allied to medicine.
- Council supports a new Academic Faculty to agree standards of advanced practice.
- Council supports a central initiative to evaluate and promote inter-professional education and shared learning.

New Labour early modernisation.

On winning the general election Mr Blair pledged 'modernisation' and investment in the NHS, outlined in the White Paper 'Modern and dependable' (DOH 1997)

should always be sufficient qualified staff available to provide advice and support to less experienced staff.

⁴² A situation identified as occurring in hospitals where patients with diverse conditions were concentrated into one ward as a result of the drive for hospital efficiency, often occurring at weekends when the number of staff in the hospital was decreased.

and a series of position statements relating to clinical effectiveness (NHS Executive 1998) and Clinical Guidelines (Mann 1998), and launch of a rolling programme of National Service Frameworks [NSFs]. In Braverman terms these structural initiatives are nothing more than the tools of scientific management whose desire is to reverse production process control into the hands of management⁴³.

A new vision for nursing's future was then launched under the cliché 'Making a difference' (DOH 1999), which set out a new pay scale and clinical career structure for non medical staff in the NHS, resumed in appendix 11. This was closely followed by the NHS Plan (DOH 2000a), a 10 year plan for NHS reform, emphasizing 'patients always come first' with 'frontline staff having more responsibility'. The Chief Nursing Officer [CNO] responded to the NHS Plan with 10 key roles for nurses (DOH 2001a) listed in figure 18, indicating the beginning of a second wave of RN up-skilling⁴⁴.

Figure 18: 10 key roles for nurses (DOH 2001a).

1. To **order diagnostic investigations** such as pathology tests and x rays.
2. To **make and receive referrals** direct, say to a therapist or a pain consultant.
3. To **admit and discharge patients** for specified conditions and within agreed protocols.
4. To **manage patients** for specific conditions and within agreed protocols.
5. To **run clinics**, say for ophthalmology or dermatology.
6. To **prescribe** medicines and treatments.
7. To carry out a wide range of **resuscitation** procedures including defibrillation.
8. To **perform minor surgery and outpatient procedures**.
9. To **triage patients** using the latest information technology to the most appropriate health professional.
10. To **take the lead** in the way local health services are organised and in the way they are run.

Concerns regarding the quality of hospital patient care.

⁴³ and away from health professionals through driving through the NHS structures to make transparent the labour process, introducing 'tick the box care' and a route for management to employ detail workers as opposed to health professionals.

⁴⁴ The first wave being as a result of the Greenhalgh and Company (1994) report.

Amidst NHS modernization New Labour were forced to deal with their first winter bed crisis, giving priority to emergency hospital admissions which resulted in a further increase in hospital waiting lists. The following year the winter crisis occurred again during which the media focused on patients being transported across the country to be accommodated in critical care beds⁴⁵. A media frenzy culminated in debates as to why there was a crisis within Acute Trust critical care provision. Several discourses evolved as to the reasons for the crisis, the foremost explanation was that demands for critical care beds had risen as a result of the dependency and acuity of patients on general wards increasing. But this was not the whole story, because one explanation that evolved was a shift in skill mix on general wards from RNs to unregistered HCAs, a view supported by the RCN who suggested from 1992-1999 there had been a 2% decrease in the ratio of qualified to unqualified staff. Smith and Wood (1998) demonstrated changes in skill mix had major effects on patient outcomes when they described how patients on general wards who underwent a cardiac arrest call had abnormal clinical observations and laboratory results before their condition had worsened to the point of cardiac arrest. This explanation led to a further assertion exposed widely across the profession on publication of two studies (McQuillan et al. 1998, and McGloin, Adam and Singer 1999), that of sub-optimal general ward care.

The concerns raised regarding hospital care for the acutely and critically ill patient culminated in government issuing 'Comprehensive critical care' (DOH 2000b), a radical new strategy for the provision of hospital 'critical care' through modernization, described as patient focused, based on patient need

⁴⁵ Critical care beds comprise: **Intensive Care Units (ICU)** beds, defined as 'a service for patients with potentially recoverable diseases who can benefit from more detailed observation and treatment than is generally available in general acute wards'; **High Dependency Units (HDU)** beds which provide a standard of intermediate care between general wards and ICU which enables monitoring and support for patients at risk of developing organ failure, in addition to offering a step down facility from ICU.

rather than location [in the hospital]⁴⁶. The national expert group who developed the comprehensive critical care strategy (DOH 2000b) made no recommendations to investigate WHY sub optimal general ward care was occurring in the first place, but proceeded to replace existing arrangements for housing hospital patients, based on where care was delivered ie General acute wards or HDU / ITU, by introducing the new concept 'levels of acute care' which were to be determined by an assessment of patient need out of which came a patient 'severity of illness and dependency' scoring system, shown in figure 19.

| | |
|---|---|
| Figure 19: Levels of acute care (DOH 2000b). | |
| Level 0 | Patients whose needs can be met through normal ward care in an acute hospital. |
| Level 1 | Patients at risk of their condition deteriorating, or those recently relocated from higher levels of care, whose needs can be met on an acute ward with additional advice and support from the critical care team. |
| Level 2 | Patients requiring more detailed observation or intervention including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care. |
| Level 3 | Patients requiring advanced respiratory support alone or basic respiratory support together with support of at least two organ systems. This level includes all complex patients requiring support for multi-organ failure. |

This new critical care led strategy meant patients' in acute hospital beds could 'theoretically' move up or down the newly defined levels according to their clinical condition, the strategy aimed to facilitate smooth patient transfer between critical care and general wards.

In an attempt to address the situation where patients deteriorating condition on general wards went undetected, critical care 'Outreach' services were set up (Coombs and Dillon 2002) staffed by critical care RNs who follow up patients

⁴⁶ a situation blamed on critical care services having evolved haphazardly, resulting in their

discharged from critical care and through their surveillance role on general wards could recognize actual and potential patient deterioration, with the aim of providing an early intervention response. In conjunction with the 'outreach' surveillance system what evolved were early warning systems (O'Dell et al. 2002) for general ward staff, a new charting system for nursing staff to record patients vital observations in order to detect earlier when a patients condition is potentially deteriorating.

These so called 'outreach' critical care services were implemented without anyone publicly questioning why there was a need for them in the first place. Why were nursing staff on general wards unable to detect when a patient's condition was giving rise to clinical signs of deterioration, some have suggested the comprehensive critical care strategy was a government knee jerk reaction around the time of a pending election. Why I ask if RNs are prepared adequately for their role in caring for acutely ill adult medical and surgical patients do they need a 'checklist' (MEWS) to detect patient deterioration ?.

The end of an era.

This era drew to a close on the basis of professional concern regarding the quality of the 'new' RN, concerns so widespread across the profession led to a commission to propose a way forward for pre registration nurse education to enable 'fitness for practice'. The Commission's [Peach] report (UKCC 1999) indicated reservations about recruitment, selection, the theory-practice gap, student nurse placements, evaluation of outcomes and joint working with service, culminating in numerous recommendations outlined in appendix 12, and policies on future student nurse preparation. For hospital RNs the most important recommendation emanating from Peach came in the joint policy statement 'Placements in focus' (ENB/DOH 2001), which because the PREP requirement for a period of support for new RNs had not been mandatory was rectified through

random and variable provision.

placing on statute new guidance on the role of the RN as a mentor and requirements for preparation to perform this role.

Concerns also came to light from the NHS patient survey 'all was not well' in relation to the provision of basic care in hospital wards. Findings addressed by launch of the Essence of Care (DOH 2001b), containing 10 patient focused benchmarks listed in Figure 20, a somewhat concerning strategy for RNs, launched without addressing WHY basic care was not up to patient expectations.

Figure 20: Essence of care benchmarks (DOH 2001 p.8).

- Principles of self care
- Hygiene
- Food and nutrition
- Personal and oral hygiene
- Continence and bladder and bowel care
- Pressure ulcers
- Safety of clients / patients
- Record keeping
- Privacy and dignity

This era draws to a close as NHS modernization shifted to RNs in Primary Care, in publications like 'Liberating the talents' (DOH 2002a), and 'Shifting the balance of power' (DOH 2002b), in an increasingly Primary Care led NHS opportunities for RNs with acute care expertise evolved, resulting in many experienced hospital RNs moving into Primary Care.

ERA 4: From new roles for RNAs to anarchic government agendas.

The current era commenced when the UKCC and the four National Boards for education, were replaced by the Nursing and Midwifery Council (NMC), who issued a new three part professional register, where the 'old' trained RGN (UKCC Part 1) and the 'new' Adult Nurse (UKCC Part 12) registrants merged and were renamed Registered Nurse Adult (RNA). The NMC brought into being three types of 'specialist' community Public Health Nurses shown in table 6.

Table 6: The new three part register (NMC 2004).

| Part of the register | Sub parts | Registration entry code. |
|---|-----------------------------|--------------------------|
| Part 1) Nurses | Sub part 1 | |
| | Adult | RN1 - RNA |
| | Mental Health | RN3 - RNMH |
| | Learning disabilities | RN5 - RNLD |
| | Children | RN8 - RNC |
| | Sub part 2 | |
| | Adult | RN2 |
| | Mental Health | RN4 |
| | Learning Disabilities | RN6 |
| | General | RN7 |
| | Fever | RN9 |
| Part 2) Midwives | | RM |
| Part 3) Specialist community Public Health Nursing | Health Visiting | RHV |
| | School Nursing | RSN |
| | Occupational Health | ROH |
| | Family Health ⁴⁷ | RFHN |

On the press of a button RNs with specialist JBCNS/ ENB courses recorded on the UKCC register had these 'de recorded', as the NMC introduced three groups of recordable qualifications shown in table 7.

Table 7: Recorded qualifications (NMC 2004).

| | |
|--|------|
| <i>Prescribing</i> | |
| Mode 1 prescribing | V100 |
| Extended Nurse Prescribing | V200 |
| Extended / supplementary prescribing | V300 |
| Specialist practitioner (SP) | |
| SP Adult Nursing | SPAN |
| SP Mental Health | SPMH |
| SP Childrens Nursing | SPCN |
| SP Learning Disability Nursing | SPLD |
| SP General Practice Nursing | SPGP |
| SP Community Mental Health Nursing | SCMH |
| SP Community Learning Disabilities Nursing | SCLD |
| SP Community Childrens Nursing | SPCC |
| SP District Nursing | SPDN |
| Lecturer / Teaching | |
| Lecturer / Practice Educator | LPE |

⁴⁷ **Family Health** applicable in Scotland where a programme is being piloting, a combined generic programme at Stirling University.

An NMC circular was then released on their web site stating the 'Scope of Professional Practice' was no longer applicable and that the new NMC (2002) Code of Conduct stressed registrants' 'personal accountability for practice' and incorporated guidance on enlarging the RN's scope through placing a specific requirement on the Nurse to

Acknowledge the limits of your professional competence and only undertake practice and accept responsibilities for those activities in which you are competent. If an aspect of practice is beyond your level of competence or outside your area of registration you must obtain help and supervision from a competent practitioner until you and your employer consider that you have acquired the requisite knowledge and skill (p.8).

Accelerated NHS modernization and the role of the Hospital RN.

Inception of the NMC and its new apparatus for registrants set the backdrop for accelerated change in the NHS, with RN up-skilling gaining momentum in relation to the CNO 10 key roles through publication of a guide to developing nurses' roles (DOH 2002c)⁴⁸, emphasized only two of the 10 roles had specific legal boundaries: ordering diagnostic investigations, for example X-rays, and prescribing medicines/treatments. Legislative constraints the DOH guidelines indicated could be overcome through development of local protocols to enable RNs to order diagnostic investigations, and through new legislation on non medical prescribing. These two developments meant RNs could, with the right preparation, up-skill into one, more or all of the 10 key roles.

Launch of the 'More staff working differently' (DOH 2002d), the NHS Human Resource (HR) strategy built on 'four pillars' listed in figure 21, laid down the

Figure 21: Four Pillars of the NHS Human Resource strategy (DOH 2002d. p.7)

- 1) Making the NHS a model employer.
- 2) Ensuring the NHS provides a model career through the concept of the skills escalator.
- 3) Improving staff morale.
- 4) Building people management skills.

⁴⁸ providing case examples where this had already occurred and urging managers to 'learn from the experience of those who have started to develop key roles (ibid., section 3).

structural foundations government needed for the modernization of non medical staff careers. Pillar two introduced the 'skills escalator', placing RN up-skilling firmly at the center of the government modernization agenda:

A model career is one in which there is an expectation of lifelong learning and development, with opportunities for advancement and progression. The skills escalator encapsulates this approach. Staff are encouraged and assisted to move up the escalator by renewing and extending their skills and knowledge. At the same time roles and workload are delegated down the escalator, generating efficiencies and skill-mix benefits (ibid., p.8).

Underpinning the HR strategy was a further development, pay modernization in the form of 'Agenda for Change' (AfC) for all non medical staff in the NHS, described as:

reforms to create a fair pay system Critical in improving recruitment and retention and encouraging new working practices. Pay reforms will underpin the Skills escalator, facilitating new types of skill mix and providing stronger incentives for staff to acquire new knowledge and skills (ibid., p.21).

The focus then turned to 'systems re-engineering' (DOH 2003a) in five areas of NHS service delivery, listed in figure 22. For the Acute Trust RN the

Figure 22: Five key areas for systems re-engineering in the NHS (DOH 2003a).

Treatment centres to provide care for 500,000 annually, (concentrating on elective surgery, providers being Acute Trusts or Private sector hospitals).

Separation of elective from emergency work - and possible separation of medicine from emergency surgery, (offering fast track surgery on a day case or 24 hour system).

Case management of long term condition patients to minimize repeat admissions

Reorganisation of medical staffing to move from on-call to shift work a necessity of the European Working Time Directive.

Integrated Care Pathways (ICPs) defining the steps in the care of patients with a specific condition, detailing the progress expected to achieve consistent evidence based management (shorter hospital stays and improved clinical outcomes).

separation of elective from emergency surgery, and the increasing provision of elective surgery in private sector/dedicated treatment centers, combined with

the 're-organisation of medical staffing' would undoubtedly impact on NHS surgical ward RNs, due to them being the most likely group to absorb the shift work of Junior Doctors.

Before systems re-engineering could be implemented the now newly created 'modernisation agency' launched '10 high impact changes' (DOH 2004a) for improving hospital systems listed in figure 23. High impact change 10: re-design and extend roles, being described as 'all about optimizing roles along an agreed

Figure 23: 10 high impact changes (DOH 2004a).

1. Treat day surgery as the norm for elective surgery.
2. Improve access to key diagnostic tests.
3. Manage variations in patient discharge.
4. Manage variations in patient admission.
5. Avoid unnecessary follow-ups.
6. Increase reliability of performance interventions: a care bundle.
7. Apply a systematic approach to care for people with long term conditions.
8. Improve patient access by reducing the number of queues.
9. Optimise patient flow using process templates.
10. Redesign and extend roles.

pathway or process of care' (ibid., p.10), with three hospital labour forces identified as requiring 'role re-design': 1) administration and clerical, 2) assistant practitioners and 3) advanced practitioners, described in Figure 24. Government urging every NHS organization to consider the maximum potential of the three worker categories when re-designing services.

Figure 24: Three categories of role re-design (DOH 2004a, p.10).

Administrative and Clerical: extending administrative and clerical roles releases care-givers from administrative duties and improves communication between providers and patients.

Assistant Practitioners: are healthcare workers with a level of knowledge and skill beyond that of the traditional healthcare assistant or support worker. They deliver care and undertake tasks that previously have been within the remit of registered professional staff.

Advanced Practitioners: are experienced clinical professionals who have developed their theoretical knowledge and skill to a very high standard, such that they have a level of decision making and often have their own caseload. They are able to undertake tasks that would previously have been performed by another professional.

Modernisation of the non medical NHS human resource became clearer on launch of a nine level Career framework [CF] shown in Table 8, of the nine levels five (CF 5-9) relate to the RN, with CF levels corresponding with AfC pay bandings.

Table 8: The NHS Career Framework [CF] levels 5-9 applicable to the RN (Skills for Health 2007)

| Level | CF Title | Career Framework Description |
|-------|-----------------------------------|---|
| 5 | Practitioners | Most frequently registered practitioners in their first / second post-registration / professional qualification jobs. |
| 6 | Senior / specialist practitioners | Staff who would have a higher degree of autonomy and responsibility than 'practitioners' in the clinical environment, or who would be managing one or more service areas in the non clinical environment. |
| 7 | Advanced practitioners | Experienced clinical professionals who have developed their skills and theoretical knowledge to a very high standard. They are empowered to make high level decisions and will often have their own caseload. Non-clinical staff at Level 7 will typically be managing a number of service areas. |
| 8 | Consultant Practitioners | Staff working at a very high level of clinical expertise and / or have responsibility for planning of services. |
| 9 | More Senior Staff | Staff with the ultimate responsibility for clinical caseload decision making and full on-call accountability. |

The final piece in the modernization re-structuring jigsaw was revealed on launch of the NHS Knowledge and Skills Framework [KSF] (DOH 2004b), which defined the knowledge and skills for pay banding and career progression for all non medical staff in the NHS.

Junior Doctors' further impact on the RN role.

Junior Doctors continued their campaign to become true 'trainees' (HPERU 2002)⁴⁹, and for an improvement in their working lives, particularly related to night duties, in response the Modernisation agency (2004) launched the 'hospital

⁴⁹ Also at this time the GMC (2002a) published its Implementing the new deal guidelines, followed by Tomorrow's doctors (GMC 2002b) and the DOH (2003b) modernizing medical careers strategy.

at night' report, which recommended that non medical staff take on a proportion of the work traditionally performed by Doctors at night, and that there was a need to reduce unnecessary duplication of work seen when there is multiple clerking (p.1.1.2). The report concluded compliance with the EWTD for Junior Doctors lay in role redesign, to enable extending of the scope of work carried out by non-medical staff. In August 2006 medical graduates entered the first programme of a new curriculum, House Officers were re-named Foundation Year one (FY1's) and Senior House Officers, Foundation Year two (FY2's). Although a landmark for Junior Doctors no-one has studied these effects on RNs in areas where the new FY 1 and FY 2 Doctors are employed⁵⁰.

The Royal College of Nursing (RCN): it's work falls on deaf ears.

The RCN have worked tirelessly to offer a counteracting force to the realities of NHS modernization for its members. At the beginning of this era they published two key research projects. First was 'Defining Nursing' (RCN 2002a) which culminated in articulation of a new definition of nursing:

Nursing is The use of clinical judgement and the provision of care to enable people to promote, improve, maintain, or recover health or, when death is inevitable, to die peacefully (p. 1).

Closely followed by 'Quality education for quality care' (RCN 2002b) in which it stressed the RCN's continued belief that nurse education

... is central to enabling skilled nursing care in order to improve outcomes for patients and staff. A better educated workforce, which has equity in terms of opportunities will lead to higher standards of patient care and improved health outcomes (p.3).

The RCN then turned to debating 'the future nurse' (RCN 2003) through raising issues about multiskilling, development of a flexible healthcare workforce, and role substitution, issues they contextualised to the wider issue of better patient

⁵⁰ This is not the end of the Improving Working Lives (IWL) agenda for junior doctors as further EWTD changes are due for implementation.

centred care (p. 4), raising the profile of role substitution when they stated this was occurring in the NHS in three ways:

- Between professional groups eg from hospital to community nurses
- Across professional groups eg from doctors to nurses
- Across professional and non professional groups eg from RNs to HCAs

These projects seemed to springboard the RCN into a course of research in response to members' concerns regarding Nurse staffing, although a major study commissioned by the RCN (Buchan 2004) concluded 'how best to determine staffing levels has not reached any conclusion at a national level' (p.3).

All continues not to be well in hospital wards.

Since launch of the NMC and the government's NHS Plan secondary health care appears to be bedevilled with concerns regarding the quality of care for its patients, and the quality of new RNs opting for a career in the acute sector of the NHS. Of particular concern has been the support and supervision of student nurses by RN's, raised by Duffy (2004) in her 'failing students' research, during which she found a reluctance in the RN community to fail students, despite their lack of fitness for purpose leading to the recommendation for improvements in RN mentor training.

A further concern regarding secondary care came to light in the report 'An acute problem' (NCEPOD 2005) which revealed 1:10 patients had an incomplete admission process, patients often had prolonged periods of physiological instability prior to admission to ITU, with 66% of patients admitted to ITU having, when their records were reviewed, been physiological instability for more than 12 hours⁵¹, 33% of patients who died were reported as having received less than good care on general wards.

⁵¹ despite the launch of comprehensive critical care and critical care outreach, attributing this to many hospitals having not implemented these initiatives.

In addition to the NCEPOD report, the media have exposed rising concerns as to the quality of care in the acute hospital in terms of hospital acquired infection (HAI), the undercover nurse series which demonstrated poor standards of care to older people, and a well known journalist wrote about her sister's appalling end of life care (Street Porter 2006). The most recent and concerning guideline regarding secondary care is the 'Safer care for the acutely ill patient' launched by the National Institute for Clinical Excellence (NICE 2007) a new framework for recognition and response to acute illness in hospitalized patients, again without any questions being asked as to why this was occurring in the first place.

The current era continues.

On one hand the current era is characterized by an unprecedented, almost anarchic opportunity for RNs to expand or extend their role, as long as it fits into the government agenda of 'service improvement', 'working in new ways', and 'role re-design', the buzzwords of the government's modernization agenda. Whilst on the other hand, English RN trainees are being encouraged to enter the increasingly demanding and up-skilled nursing profession with less entry qualifications because these have been relaxed from five GCSEs to 'or equivalent' NVQ level 3 prepared HCAs.

Against this backdrop there is a decline in the uptake of post registration specialist clinical courses for new generalist prepared adult RNs, as a result of this the Council of Deans (2006) called a crisis meeting, voicing concerns regarding cuts in funding for Nursing, Midwifery and Allied Health Professionals education⁵², emanating from up to a 25% reduction in Strategic Health Authority (SHA) commissioning, of which 10-30% reductions were in post registration and continuing professional development programmes, exacerbated by SHAs withdrawing funding from NHS Trusts to support the release of staff for education.

⁵² gleaned from collated data from 60 universities who provide health care education.

The future direction for RN post registration careers has recently been launched by the Department of Health (2007) and outlined in figure 25, and the current source of debate and discussion within the nursing profession.

Figure 25: The five pathways: Towards a framework for post registration nursing careers (DOH 2007).

- Children, family and Public Health.
- First contact, access and urgent care.
- Supporting long term care.
- Acute and critical care.
- Mental Health and psychosocial care.

Resume Chapter 1.

The 1919 Nurses Act brought into being Registration for hospital based 'General' Nurses, the subsequent 88 years have in this chapter been conceptualised into four eras based on the author's understanding of 'landmarks' which enabled or restricted the RN to develop, expansion or extend his / her role. The four eras and the author's descriptors of them are outlined in table 9.

Table 9: Conceptualisation of the four eras of hospital registered 'General / Adult' Nursing.

| Era | Date | Years | Descriptor of Nursing. |
|------------|--------------|--------------|---|
| 1 | 1919-1977 | 58 | Traditional nursing. |
| 2 | 1977-1992 | 15 | Early modernization. |
| 3 | 1992-2002 | 10 | Widespread modernization and Nursing professionalization. |
| 4 | 2002-present | 5 | Re-modernization. |

Era one constitutes 58 years of the General Nurse 'traditional' apprenticeship, which equipped the SRN with the knowledge and skills to manager an adult general ward in the absence of the Ward Sister. For some SRNs medical specialization offered access to specialist post registration courses, although these were only available for the minority. For the majority of SRNs promotion

in the hospital was through clinical experience in their chosen specialism. During this era terms like role development, role expansion and role extension were not in the repertoire of nursing until Briggs raised the issue of overlapping functions between Doctors and Nurses.

Era two commenced on issuing of the extended role circular, which signalled that SRN role development was through certification by a doctor, but this was also an era of 'early nursing modernization' as a result of nurses themselves looking to become more nurse led and holistic.

Era three, although only a single decade is the true era of widespread 'nursing modernization and professionalization'. Changes in General Nurse training led to widespread implementation of Team and Primary Nursing, the nursing process and nursing models, alongside RNs being enabled to access diploma and degree programmes in their clinical speciality, recordable on the UKCC register.

The present era is the shortest era in Nursing's regulated history, and what I would describe as the 're-modernization' of hospital registered nursing. It commenced on inception of the NMC and major changes to registerable and recordable qualifications. For five years government initiatives have been re-structuring NHS service provision, RNs being key players in this through the accelerated up-skilling agenda, with Primary Care / Community Nursing taking precedence in the newly created Primary Care led NHS, with little or no focus on the RN who chooses a career in the Acute Trust.

Chapter 2: 'Assistants' to the Registered [General] Nurse in Hospital wards⁵³.

Passing of the 1919 Nurses Act regulated the use of the title Nurse, subsequently there have been 'assistants' to support RNs in hospital wards, with which the RN has encumbant upon them a responsibility for this labour force. Throughout this era a skilled, semi-skilled and un-skilled labour force of assistants to the RN were employed in hospital wards.

ERA 1: Apprentices, true Nursing Assistants and Nursing Auxiliaries.

This era commences with passing of the 1919 Health Care Act which failed to exclude the unqualified from the nursing workforce (Stokes and Warden 2004).

The apprentice General Nurse.

The mainstay assistant labour force in hospital wards came into being on passing of the 1919 Nurses Act, the General Student Nurse for the hospitalised medically and surgically sick adult, a GNC three year apprenticeship. The General Nurse syllabus after several revisions culminating in eight core subjects which formed the 'Pillars of Nursing theory and practice' shown in figure 26.

Figure 26: Eight core subjects for General Nurse examination (GNC 1969).

1. Elementary anatomy and physiology,
2. Hygiene,
3. First aid,
4. Theory and practice of nursing,
5. Materia medica and therapeutics,
6. Medical Nursing,
7. Surgical Nursing,
8. Gynaecology.

⁵³ The use of untrained Nurses prior to the Nurses Act is reported to have occurred at times of nurse shortages where middlemen provided agencies employing girls with incomplete training or no training at all (Abel Smith 1960), at the time anyone could call themselves a Nurse, leading to the sick not knowing who was caring for them ...

in the crisis of sickness, the stricken family did not stop to check a qualification; the problem was as they saw it, was to get a nurse as quickly as possible (ibid., p.58).

The General Nurse syllabus was revised in 1952 to include human behaviour in illness and the social aspects of disease in response to the changing social and medical environment (Jolley and Darling 1982). In 1969 the GNC issued a new syllabus which contained a clinical schedule book for recording practical instruction and four statutory practical assessments shown in appendix 13, ensuring the apprentice could demonstrate their skill acquisition in order of complexity⁵⁴. The Ward Sister throughout this era was helped in her role with students by the on-site School of Nursing Tutors (RNT) and Clinical Teachers (RCNT) as a result of their monitoring of students on placement and supporting RNs in their role in performing the statutory practical assessments. Success in the statutory practical assessments was followed by the Student Nurse final test, the state final examination. On completion of the apprenticeship the new SRN was well equipped to manage a hospital ward for a span of duty, almost immediately following receipt of his / her registration number.

Debates regarding 'trained' and 'un-trained' assistants on hospital wards.

Following the 1919 Nurses Act Assistants other than the Student Nurse apprentice were regularly employed on hospital wards. The first concerns regarding this labour force were drawn to the attention of RNs in an editorial in the British Journal of Nursing 'The government of nurses without consent' (BJN 1935), which advised readers to carefully study a report by a Local Authority committee on which the nursing profession was not represented, the committee approved a proposal for care of the chronically sick as a separate branch of nursing, staffed with trained 'Assistant Nurses for the chronic sick' (p.73)⁵⁵.

⁵⁴ commencing with the aseptic technique, followed by conducting a medication administration round within a hospital ward. Successful achievement of the first two practicals allowed the student to progress to the third: delivery of total care for one patient for a span of duty, followed by the penultimate test of the student's nursing skill and conducted in their final year of training, managing an adult hospital ward to include liaison with medical staff, delegation of duties to staff and justification of clinical and administrative decisions to the assessing Ward Sister.

⁵⁵ furthermore the committee discussed the grading of nurses, concluding the existing nomenclature was both 'chaotic and misleading', suggesting a revised nomenclature be applied separately to General and Special Hospitals shown in appendix 14.

Essex Local Authority also reported they had a two year training programme for untrained nursing staff in hospitals for the chronic and infirm aimed at improving standards of care (Bendall and Raybould 1969). The issue of staffing hospitals housing the Chronic Sick then gained momentum as a result of the 'Essex scheme' being debated at a nursing conference, delegates agreeing this could lead to a cheaper grade of labour. The College of Nursing were asked for their views on a special grade of Nurse for the Chronic Sick, their response pointed out a register of nurses for the chronic sick was unlikely as pressure had failed to establish a register for Tuberculosis (TB) Nurses.

In preparation for WWII the GNC approval a roll for a second grade of worker to carry out domestic nursing duties in wards in chronic institutions and in the community. This occurred at the same time as the Ministry of Health establishing the Athlone Committee to inquire into 'persons engaged in nursing the sick', although its work was overshadowed by the threat of war and the work of the Committee for Imperial Defense whose job was to compile a register of 'Assistant Nurses' and 'Nursing Auxiliaries' for emergency hospital services, they appealed for those who had nursing experience to form the Civil Nursing Reserve (CNR). The CNR recruited a female labour force of 7,000 Nurses and 3,000 Nursing Assistants, and a new contingent of untrained volunteer helpers, the 'Nursing Auxiliary' (NA) who were given 50 hours training before being allowed onto hospital wards to perform domestic duties, which resulted in three groups of assistants in hospital wards: the student apprentice, the semi-trained Nursing Assistant and the nominally trained NA. The CNR according to Baly (1980) consisted largely of Nursing Assistants who had no standard training, were hastily put together and were a burden to those supervising them, 'more about availability than suitability' (p.180).

The regulation and training of the 'true' Assistants to the RN.

The interim Athlone report (HMSO 1939) recommended an increase in the number of orderlies and ward maids to relieve nursing staff of non-nursing tasks

and the setting up of a GNC roll for 'Nursing Assistants'⁵⁶ (Baly 1980). The MoH then asked the GNC to consider a roll for Nursing Assistants, the key objection aired in the nursing press was that a roll could lead to the degrading of the RN (BJN 1939). The RCN responded by setting up the Horder review, although later that year the GNC announced they had approved the roll on the condition legislation was passed. The first Horder report focused on the Nursing Assistant, suggesting their recognition would allow more RN time for hospital work and improvements in Student Nurse training. The report went on to suggest where the 'Assistant Nurse' should work:

Not only should the Assistant Nurse look after the chronic sick; there was a place for her, under proper safeguards in factories, certain health centres, nursing homes and small institutions at present trying to solve their staffing problems - largely by means of student labour (RCN 1941-1949).

Horder reinforced the Nursing Assistant should no longer be regarded as an inferior or second grade helper, instructed to carry out work RNs find uninteresting and therefore will not do, suggesting stricter tests for existing Nursing Assistants to enter the roll⁵⁷ than in the Athlone report⁵⁸. Passing of the 1943 Nurses Act made the GNC keeper of the roll and laid down rules for admitting existing Nursing Assistants during a two year period (Abel Smith, 1960, p.173)⁵⁹.

⁵⁶ for those who had completed a recognised training programme where the name 'assistant nurse' be retained and protected by law (Baly 1980).

⁵⁷ The committee recognised it to be unfair to 'close the profession' without making arrangements for nurses who could have registered but failed to. Conditions for admission to the roll were stricter than in 1925. In addition to the 1925 criteria, practicing nurses were required to have either a certificate of 3 year general training or a total 10 years practice. For nurses over 30 years, certificate of competence and evidence of 5 years' experience, under 30 years, 2 years' service in hospitals under supervision.

⁵⁸ by proposing nursing co-operatives and agencies be inspected and have an SRN as professional supervisor, with the Assistant Nurse only working in private practice under supervision (ibid., p.173).

⁵⁹ who 'for a prescribed period' had been bona fide engaged in practice as nurses under conditions which appear to the Council to be satisfactory for the purposes of this provision and have such knowledge and experience as to justify their enrolment (Nurses Act 1943). The Council was to frame the exact rules for the list of practicing nurses, the Act was made more specific persons who were to be admitted who held satisfactory certificates from an institution showing they had completed before July 1925 a course of training in nursing in the institution and who satisfy the

With the exception of the apprentice Student Nurse and the new Nursing Assistant under instruction, the practice of nursing was limited by law to the SRN and State Enrolled Assistant Nurse (SEAN), nursing was defined as 'tending for reward a sick person or persons under the charge of a registered practitioner (Nurses Act 1943 sec. 2[2]c), nursing became a closed profession, although Mrs Bedford Fenwick opposed the Act⁶⁰.

In 1945 the GNC Syllabus and Rules of training for the Enrolled Nurse were published, stipulating a two year practical training, year one spent in a hospital for the chronic sick followed in year two by a nine month period in a special hospital, after which the Pupil Nurse was assessed by a quiz and a practical examination, their primary purpose being preparation for care of those with chronic conditions. BY the end of 1946 24,612 Nursing Assistants were entered onto the roll, in 1947 the roll was re-opened to admit existing Nursing Assistants who were finding it difficult to secure work due to the restrictions on use of the title nurse imposed by the 1943 Nurses Act. Implementation of the roll and SEAN training was thought to lead to an ample supply of staff to care for the sick, but this was not the case (Richards 1996), so the MoH enlisted more Nursing Auxiliaries, a role developed from the hospital orderlies whose duties were domestic, some of these recruits were then awarded the Enrolled Nurse qualification if deemed suitable by their employer.

Council they are of good character and have adequate knowledge and experience of nursing (Nurses Act 1943).

⁶⁰Mrs Bedford Fenwick returned to her post in the central lobby of the House of Commons, hailing the phrase 'one portal'. In april 1943 Mrs Bedford Fenwick protested about the Act:

For the enrolment (registration) of semi trained nurses, known as Assistant nurses and the recognition of thousands of women with nebulous, untested qualifications who during the past 20 years have failed to qualify themselves by examination for state registration ... Future generations of nurses will suffer from the disastrous registration thus inaugurated (Abel Smith 1960, p.37).

In 1948 a moratorium on training for the roll resulted in the 1949 Nurses Bill which implemented two major changes, first the stipulation the SEAN was trained for care of the chronic sick was dispensed of, allowing General Hospitals to become Pupil Nurse training institutions, which was encouraged in a health circular from the Ministry of Health to Local Health Authorities. Second was the issuing of a revised training syllabus reducing SEAN training to one year followed by an examination. If the Pupil Nurse passed the examination they were then required to work for a further year under supervision before being enrolled. In 1949 the roll was re-opened to allow those who had been prevented by war from applying (Abel Smith 1960, p.220).

The next development for the SEAN occurred following presentation of a report to government pointing out the term 'Assistant' in their title was disliked, and a deterrent to recruitment. The GNC and MoH discussed removing the term 'Assistant' from the legal title, followed by an Enrolled Nurse rules approval order (1961), which although the order made no direct reference to removing the term 'Assistant', stated the roll of 'Assistant Nurses' was to be known as the Roll of Nurses, a revised syllabus of training for ENs was introduced (GNC 1964), which from 1966 became a compulsory two year programme, comprising six months medicine, six months surgery, three months long stay and eight weeks paediatric experience.

'Un-trained' assistants in hospital wards.

Following creation of the NHS the number of Nursing Auxiliaries (NAs) steadily rose, creating a third grade of staff in most hospital wards. The work of the Auxilliary was meant to be under the direct supervision of the RN, but as Richards (1996) points out they became a group working on their own, performing tasks based on patients physical needs, undertaking ward housekeeping and helping Junior Student and Pupil Nurses, although preparation for their role amounted to little more than hospital orientation to routines, and some sporadic training. This situation was raised in a Nursing Times editorial

(1962), which indicated the proportion of NAs had risen and RNs declined over the last decade. The MoH responded by acknowledging the statistics produced up to June 1963 were somewhat misleading due to the title 'nurse' being applied loosely (Baly 1980, p.233). They also acknowledged this was occurring at a time when ward nursing teams were becoming more complex due to the wider range of team members' ability and understanding which consequently took more RN time and skill to organise (p.234).

The Platt report (HMSO 1964) recommended the reform of nurse education and proposed the need for a new grade of ward assistant, on the lines of an apprenticeship training under the aegis of the School of Nursing, and rationalization of the position of Nursing Auxiliary and Ward Orderly. The new grade of ward assistant Platt suggested should be created from those who wish to give service to the sick, but who could not, or did not, wish to train as Nurses, a labour force which should be given in-service training.

During the 60's recruiting and retaining student and trained SRNs continued to be difficult, ward staffing was maintained by recruiting overseas nurses and auxiliary grades, which led to concerns standards of care were being lowered, at a time when there was an increased intensity of care required by patients on hospital wards. Carr (1968) in response to the rising number of Nursing Auxiliaries (NAs) raised the question when is an NA not a 'nursing' auxiliary ?, reporting this labour force were increasingly holding positions of responsibility, carrying out a wide range of nursing duties RNs were either unable or unwilling to do.

The end of an era.

The era drew to a close when Skeet (1977) published an occasional paper on 'nursing aides, auxiliaries and assistants', emanating from a three year project sponsored by the Leverhulme trust, where she defines health auxiliaries as

'those whose responsibilities are defined by the tasks undertaken rather than being based on a background of theoretical knowledge' (p.145).

ERA 2: Substituting skilled trainees and trained assistants with support workers.

This era commenced just after the Briggs report when RNs were subjected to the extending role mandate and Student Nurses continued to be apprentices, and the major hospital ward labour force. On this backdrop there evolved government moves to replace training apprentices (student nurses), trained assistants (ENs) and the un-trained NAs with support workers.

The apprentice General Nurse.

Student nurses throughout this era formed the mainstay of assistants to the RN in General hospital wards, who on joining the European Economic Community (EEC) were subjected to EEC Directives (UKCC 1987a) stipulating the requirements for theoretical and practical experience shown in figure 27.

Figure 27: EEC directives 77/452/EEC and 453/EEC (UKCC 1987a).

Nursing students should have:

- An adequate knowledge of the sciences on which nursing is based
- A knowledge of the nature and ethics of the profession
- Adequate experience to participate in the training of health personnel
- Experience with working with other members of the health care team

After 1979 students were required to have experience in:

- | | |
|-----------------------------------|-----------|
| • General and specialist medicine | 300 hours |
| • General and special surgery | 300 hours |
| • Child care and paediatrics | 150 hours |
| • Maternity care | 150 hours |
| • Mental health and psychiatry | 150 hours |
| • Care of the old and geriatrics | 150 hours |
| • Home nursing | 60 hours |

The major change for the General student nurse came in a Rules Approval Order (SI 1983/667)., replacing the GNC syllabus with Rule 18 (1) first level nurse competencies (UKCC 1982) listed in figure 28. expanding the future General Nurse role into health promotion and illness prevention, but continuing the tradition of specifically preparing them for a role in caring for the adult medically and surgically sick.

Figure 28: Rule 18(1) Competencies for first level nurses (UKCC 1982).

- a) Advise on the **promotion of health** and prevention of illness;
- b) Recognise situations that may be **detrimental to the health** and well-being of the individual;
- c) Carry out those activities involved when conducting the comprehensive **assessment** of a person's nursing requirements;
- d) Recognise the **significance of observations** made and use these to develop an initial nursing assessment;
- e) Devise a **plan of nursing care** based on the assessment with the cooperation of the patient, to the extent that this is possible, taking into account the medical prescription;
- f) **Implement** the planned programme of nursing care provided, and where appropriate teach and co-ordinate other members of the caring team who may be responsible for implementing specific aspects of the nursing care;
- g) **Review** the effectiveness of the nursing care provided, and where appropriate, initiate any action that may be required;
- h) Work in a **team** with other nurses, and with medical and para-medical staff and social workers;
- i) Undertake the **management of the care of a group of patients** over a period of time and organise the appropriate support services.

These changes were occurring when the trend in education was modularisation, the benefit for the student nurse was that theoretical study periods were immediately followed by practice in that specialism, the true era of theory and practice integration for the apprentice resulting in a well co-ordinated modular RN programme outlined in Table 10.

After a longstanding and persistent campaign for student nurses to be supernumery to the workforce, Project 2000 was accepted in May 1988, on its implementation Project 2000 replaced all previous RN training

Table 10: 'General' Student Nurse modular apprenticeship (1987-1990).

| Weeks | Area of Training |
|--------------|--|
| 11 | Foundation Course |
| 15 | <i>General Nursing (Medicine or Surgery)</i> 2 weeks preparatory study block 12 weeks clinical practice 1 week consolidation study block |
| 15 | <i>Maternity and Paediatric Nursing</i> 2 weeks preparatory study block 6 weeks maternity practice 6 weeks paediatric practice 1 week consolidation study block |
| 15 | <i>Community and Psychiatric Nursing</i> 2 weeks preparatory study block 6 weeks psychiatric practice 6 weeks community practice 1 week consolidation study block |
| 15 | <i>General Surgical Nursing</i> 2 weeks preparatory study block 12 weeks clinical practice 1 week consolidation study block |
| 15 | <i>Trauma Nursing</i> 2 weeks preparatory study block 6 weeks Trauma Ward practice 6 weeks Trauma Department practice 1 week consolidation study block |
| 15 | <i>General Medical Nursing</i> 2 weeks preparatory study block 12 weeks clinical practice 1 week consolidation study block |
| 15 | <i>Specialist Surgical Nursing</i> 2 weeks preparatory study block 6 weeks Special Surgical Ward practice 6 weeks Theatre Nursing practice 1 week consolidation study block |
| 15 | <i>Elderly Care Nursing</i> 2 weeks preparatory study block 12 weeks clinical practice 1 week consolidation study block |
| 14 | <i>Elective</i> 1 week study block 12 weeks clinical practice 1 week study block |
| 1 | <i>Management Study Block</i> |

programmes⁶¹ with ENB (1989) outcomes. The new Student Nurse curriculum now re-housed in HE comprised an 18 month Common Foundation Programme (CFP) shared by four groups of student nurse, followed by an 18 month Branch programme, for the previous General Nurse this was the adult branch programme, reducing their specialty preparation by 50%. Project 2000 signalled the end of 60 years of speciality prepared, three year student nurse apprenticeships. No longer was the student nurse an assistant, or a member of the nursing labour force within the hospital, as a result of their three year curriculum being much broader, including more diverse placements than just the acute trust hospital. At the time the ENB (1989) described the new branch programme for adult nurses as

to prepare the students to be professional practitioners, competent to provide holistic, individualised care to meet the nursing needs of adult clients and patients at all stages of dependency and in a variety of care settings (section 1.1) ... enabling them to become professional practitioners, competent to provide effective care, with understanding ... and to accept responsibility and accountability for their actions (ibid., Section 2.1).

The Enrolled Nurse: Demise and conversion.

The 1977 EN (General) syllabus was replaced with the UKCC (1983) Rule 18(2) competencies which continued to indicate the second level nurse's role was to help / assist the RN under the direction of a first level nurse, shown in Figure 29.

Figure 29: Rule 18(2) Second Level Nurse competencies (UKCC 1983).

- a) **Assist** in carrying out comprehensive observation of the patient and **help** in assessing her care requirements;
- b) Develop skills to enable her to **assist** in the implementation of nursing care under the direction of a person in part 1, 3, 5 or 8 of the register;
- c) accept **delegated** nursing tasks;
- d) **assist** in reviewing the effectiveness of the care provided;
- e) **work in a team** with other nurses, and with medical and para-medical staff and social workers;

⁶¹ Project 2000 replaced Rule 18 competencies and the four specific three year training programmes for the General Nurse, Psychiatric Nurse, Learning Disabilities Nurse and Paediatric Nurse.

In response to concerns regarding the EN and the extended role agenda SNAC issued a report (EN 19/20) clarifying that under Item 19 of the 1983 Statutory Instrument rules approval order there were no objections to the second level Nurse performing activities which extend their role, provided they had been given training and achieved the level of competence under the direction of a first level Nurse, stressing it was not in accordance with the statutory instrument to give approval to delegation from doctors to second level nurses.

Government's agreement to Project 2000 led to the announcement that second level nurse training was to cease, and priority given to ENs becoming RGNs, which was enabled through a Statutory Instrument (UKCC 1987b) making it legal for those with only the EN qualification to enter first level nurse training programmes⁶².

The 'trained' auxiliary and rise of the semi-skilled support worker.

Briggs (HMSO 1972) recommended formal training for the Nursing Auxiliary; in response, the DHSS issued a draft circular containing guidance on this training. At the consultation stage the proposal was abandoned because the profession could not agree on duties or training for the Nursing Auxiliary (Ross 1981). Around the same time Hardie and Hockley (1978) published the first textbook dedicated to the Nursing Auxiliary, in which they pointed out their research revealed the Auxilliary was undertaking all tasks covered in the GNC RN syllabus with the exception of injections and certain forms of drainage, but training for their wide range of duties was piecemeal and haphazard, they concluded the Nursing Auxiliary was essential to the provision of hospital services, providing they were given adequate supervision. But as Ross (1981) pointed out the debates on the Nursing Auxiliary become meaningless when viewed in the

⁶² PS and D/87/04: information on EN qualification as entry to 1st level training. From 31st March 1987 an EN can apply for 1st level nursing course as an alternative entry requirement with two exceptions 1) EN by experience 2) EN as a result of three failures at RN examination, additionally have to have supporting references.

context of local staffing ratios, where there are few RNs and many Nursing Auxiliaries, and recognition of the Nursing Auxiliary performing nursing duties was gaining momentum as a result of the rising number of publications on successful in service training programmes for NAs (Courtney 1978; Johnson 1978; Keywood 1978).

The move of the student nurse labour force into HE was caveated with the nursing profession having to accept a new grade of support worker, the Health Care Assistant (HCA)⁶³. What then followed was a wealth of discourse speculating on who would be the HCA ? and what would be their preparation ? (Slack 1986). Hawthorn (1987) raised concerns as to whether the HCA would be 'an aide or a hinderance' pointing out this new worker could become increasingly depended upon in hospital wards by default, because RNs would be supervising supernumery students, whilst the 'aide' becomes responsible for day to day patient care, at the time when the DOH announced a feasibility study into extending Youth Training Schemes (YTS) into the NHS. In response health service unions COHSE and NUPE accused the government of solving NHS staffing problems and shortcomings in the job queues in one foul swoop (Seymour 1987). Nevertheless the Price Waterhouse feasibility study strongly supported YTS schemes on the backdrop of their identification of 27 schemes already in the NHS. In June 1987 it was proposed the YTS scheme be a portal for entry into the new HCA jobs within the NHS.

The NHSTA (1987) then launched the strategy for developing support workers which included establishing an NVQ system in health care:

the training of HCAs will be locally planned, delivered and funded within the framework of national qualifications. Local planning has to start by defining the skill mix required, identifying health care assistant roles and the number of people needed to fill the new posts. These roles may be made up of different combinations of clerical, housekeeping and direct care activities (NHSTA 1987, p.4).

⁶³ described as 'to provide support to RNs freeing them to provide skilled care for which they had been trained'.

followed by a support worker role framework shown in figure 30, corresponding to levels 1, 2, 3 described by the NCVQ (DHSS 1989b). NHSTA suggesting the

Figure 30: Support Worker role framework (DHSS 1989b).

| Level | Personal and social care | Housekeeping | Clerical / Administration |
|--|--------------------------|--------------|---------------------------|
| More complex i, ii, iii Procedural / routine | | | |
| | | | |
| | | | |

support worker framework was based on work undertaken on the job content and functions of Nursing Auxiliaries and Assistants which demonstrated current roles varied in terms of the levels these employees worked at⁶⁴.

The end of an era.

The RCN's initial response to the new (semi-skilled) NHS Support Worker was to announce there would be no associate membership for this grade of personnel due to their long established policy to distance themselves from non-nurses in the care team. A view which changed in 1987 when Vousden (1987a) in preparation for the agenda at the pending RCN annual conference indicated the RCN was considering admitting Nursing Assistants as members. At congress Trevor Clay the RCN General Secretary indicated he wanted to see the term nursing kept in the support worker's title because he could see their role would evolve into a Nursing Care Assistant, as opposed to a generic worker to enable this labour force to stay under the control of the nursing profession, his final statement being 'if they exist to help us, we should control them' (Vousden 1987b, p.19).

⁶⁴ Existing programmes of training for assistants then entered the nursing literature (Girvin and Clarke 1988; Harrison 1988) alongside examples of new HCA programmes (Gaze 1990; Malby 1990).

ERA 3. Formal training but no regulation of the New Nursing Assistants.

This era began on a complex backdrop for the true skilled /trained assistant to the RN, the Enrolled Nurse. The era also saw the end of General Nurse apprenticeships and their replacement in the hospital with alternative models of care delivery, enabled through the release by government of replacement monies with no stipulations as to how this was to be spent, on a backdrop of there being no national standards for staffing hospital services.

The true trained assistant, the 'Enrolled Nurse'.

The Enrolled Nurse became the focus of the UKCC lens when they dispatched 'An agenda for action' (UKCC 1997b) announcing a task force had been set up regarding the EN situation. The task force survey (UKCC 1998b) revealed the number of entrants to the register had declined since the mid 80's, they were declining in numbers in the NHS, with some hospitals no longer employing ENs. The task force concluded 'there were no jobs for ENs anymore', attributing this to the stipulation 2nd level nurses had to be supervised by a 1st level nurse as a factor influencing managers' decision not to employ ENs. The survey also revealed many ENs felt under pressure to convert, yet most were happy with their role, only 15% indicated they undertook the conversion course for better job prospects.

The UKCC (2000b) responded by pointing out the EN was entitled to call him / herself an RN, because in law the role of the nurse was not described, therefore 1st or 2nd level registration competencies at the point of registration were threshold competencies⁶⁵, which reinforced the EN was no longer an assistant but a registrant.

⁶⁵ because the UKCC under the Code of Conduct expects every registrant to maintain and improve professional knowledge and competence enabling them to renew their registration.

Semi skilled, NVQ prepared assistants.

In 1986 the National Council for Vocational Qualifications (NCVQ) was established as an independent body with no formal powers, the only way they could effect change was through co-operation with awarding industrial and professional bodies, from which evolved a five level NVQ framework, shown in table 11.

Table 11: NVQ levels 1-5 (Moore 1996).

| Level | Descriptor |
|-------|--|
| 1 | Competence in the performance of work activities which are in the main routine and predictable or provide a broad foundation, primarily as a basis for progression. |
| 2 | Competence in a broader and more demanding range of work activities involving greater individual responsibility and autonomy than level 1. |
| 3 | Competence in skilled areas that involve performance of a broad range of work activities, including many that are complex and non-routine. In some areas, supervisory competence may be a requirement at this level. |
| 4 | Competence in a broad range of complex, technical or professional work activities, performed in a wide variety of contexts and with a substantial degree of personal responsibility and autonomy. Responsibility for the work of others and the allocation of resources is often present. |
| 5 | Competence which involves the application of a significant range of fundamental principles and complex techniques across a wide range of contexts. Very substantial personal autonomy and often significant responsibility for the work of others and for the allocation of resources features strongly, as do personal accountabilities for the analysis and diagnosis, design, planning, execution and evaluation. |

NVQ programmes in Health and Social Care, led by the Care Sector Consortium, who from May 1992 developed a range of health care sector qualifications endorsed by the NCVQ⁶⁶. In the absence of statutory requirements for implementing NVQs in NHS Trusts several options evolved: 1) ignore this initiative, 2) send staff off to an established external training centre, or 3)

⁶⁶ all NVQs start with occupational standards, agreed benchmarks which specify staff performance outcomes, defining the performance expected in employment, thus assuring confidence for employers of the possessor of an award. Lead bodies for a particular occupational area did not exist before the introduction of NVQs, each represent a discrete sector of employment.

develop the infrastructure to become as an approved NVQ centre themselves⁶⁷. In hospitals adopting the NVQ system for replacing the student nurse population with semi-skilled HCAs, concerns regarding skill mix and standards of patient care began to evolve, resulting in the NHSME (1996) launch of a risk management strategy which suggested a re-profiling of hospital ward staffing because increased numbers of unqualified staff can result in inadequate supervision.

The end of an era.

This era saw replacement of student nurse apprentices, strengthening of EN preparation and for some ENs the opportunity for conversion to a 1st level RN. Finally there was a new practitioner in the hospital, the trained support worker, who as the era drew to a close the RCN agreed to allow semi-skilled HCAs with a level 3 NVQ or above, eligible to join the organisation as members.

ERA 4: Who knows: Skilled, semi-skilled or un-skilled assistants in hospital wards

The question in this present era is: Who are the assistants to the RN in hospital wards ?, a question raised because without a prescribed, statutory framework for hospital nurse staffing⁶⁸, there are numerous 'assistants' employed as part of the nursing labour force on hospital wards, listed in no particular order in figure 31.

Figure 31: Assistants to the RN in Acute Trust wards.

- NVQ levels 1,2,3 trained as HCAs.
- Ward clerk / Ward receptionist.
- Domestic staff.
- Auxilliary / HCA with no training.
- Internally trained Support worker.
- Agency / Bank Staff.
- Modern Apprentices
- Nursing cadets.
- Returners to nursing.

⁶⁷ in the form of assessors and internal verifiers of the NVQ system of vocational training.

⁶⁸ and as a result of Acute Trusts increasingly managing their own affairs.

On implementation of Agenda for Change (AfC), and the NHS non medical staff Career Framework (CF), four 'assistant' grades were established, described in Table 12, introducing a new grade of assistant , the level 4 Assistant / Associate practitioners, the true extend of this practitioner's impact on hospital service provision has yet to evolve.

Table 12: Support worker bands 1-4 (Skills for Health 2007).

| Level | CF Level Name | CF Level Description |
|-------|---|--|
| 1 | Initial entry level jobs. | Jobs such as 'domestics' or 'cadets' requiring very little education or previous knowledge, skill or experience in delivering, or supporting the delivery of healthcare. |
| 2 | Support workers. | Frequently with the job title 'HCA' or care technician - probably studying for or has attained NVQ level 2. |
| 3 | Senior Healthcare Assistants / Technicians. | This is a higher level of responsibility that support workers, probably studying for a technical qualification / NVQ level 3. |
| 4 | Assistant / Associate practitioners. | Probably studying for foundation degree, BTEC higher or HND. Some of their remit will involve delivering protocol-based clinical care that had previously been in the remit of registered professionals, under the direction and supervision of a registered practitioner. |

Control of the Second part of the NMC register.

The new NMC register merged the previous UKCC second level and first level RNs into their new framework. On publication of the NMC (2004a) standards of proficiency for student nurse education, section 4 clearly states 'there is no recognition of Second Level qualifications gained outside the European Economic Area' (EEA). The second level part of the NMC register is open only to EN's who qualified in the UK and who continue to practice as second level nurses and to second level nurses from the EEA who wish to exercise their right to freedom of movement, the NMC indicating they no longer approve educational programmes for entry to the second level part of the register.

The NMC's current position is that they recognise second level ENs continue to be prepared in other countries, but they do not accept applications from those who hold qualifications listed in figure 32, stipulating these applicants who wish to be admitted to the NMC register are required to undertake a full pre-registration training programme, with no facility for crediting prior training.

Figure 32: Second part of the NMC (2007) Professional Register.

- Enrolled nurses,
- Licensed practical nurses (LPN),
- Vocational nurse, Community nurse,
- State certified nurse,
- Staff nurse (South Africa) or
- Nursery nurse.

The current era and 'other' assistants to the hospital RN.

Recently the UK has resorted to recruiting internationally trained RNs into the NHS due to a reported nationwide shortage of home prepared RNs. To obtain NMC RN registration an 'adaptation' programme evolved for the international recruits to achieve the required competencies, during which they work at assistant grades in the NHS. A further group of assistants, increasingly prevalent within hospital wards are bank and agency nurses, who throughout the history of nursing have been used to 'fill gaps' in ward staffing (RCN 2004).

Recent publications indicate a trend in the RN community to turn their attention to researching HCAs as key players in the post millennium health care team. A survey by Keeney et al., (2005) on Nurses', Midwives' and patients' perceptions of trained HCAs found RNs and patients to view them as very effective. Spilsbury and Meyer's (2005) single case study compared what HCAs say they do, and what they actually do in practice, concluding the title 'Making claims on nursing work' was a worthy title of their study.

A 'google' search on 'Health Care Assistant & UK' will result in the Modern apprenticeship in healthcare coming up first on Learn Direct (www.learndirect-advice.co.uk) here the work of the HCA is described as:

To help health care professionals with the day-to-day duties surrounding patient care. Patients may be elderly, suffering from long-term sickness, recovering from surgery, have mental health problems, physical disabilities or learning difficulties.

with their work domain listed in Figure 33, and the skills and interests for the

Figure 33: The work of the Health Care Assistant (Learn Direct 2007).

- Helping keep patients clean
- Helping patients to eat and dress
- Toileting
- Making beds
- Measuring and recording temperature, pulse and respiration
- Taking and testing urine samples
- Chatting to patients
- Supporting patients with mobility problems

role as an HCA outlined in figure 34.

Figure 34: The skills and interests to be a Health Care Assistant (Learn Direct 2007).

you should:

- be friendly and outgoing, able to relate to people from a wide variety of backgrounds
- be tactful and sensitive, particularly when helping patients with personal care
- not be embarrassed or squeamish about personal and unpleasant tasks
- treat patients with respect
- be physically strong for lifting and supporting patients
- be gentle, as many patients will be frail
- be able to work on your own initiative or as part of a team
- be reliable and patient with a sense of humour.

The most important report regarding the support workers / assistant grade in health care came from an RCN (2006b) collaboration with other non-medical

professional bodies who point out the term support worker is denoted by a variety of titles listed in figure 35,

Figure 35: Health Care Assistant titles (RCN 2006b).

- Care assistant
- Health care assistant
- Health care support worker
- Re-ablement worker
- Rehabilitation assistant
- Rehabilitation support worker
- Rehabilitation technician
- Support worker
- Support practitioner
- Team support worker
- Therapy assistant
- Assistant practitioner
- Assistants
- Technical instructors

a situation their members have indicated they are increasingly concerned about:

there is currently no national policy that determines a single name for this group of workers. Numerous titles exist to reflect the many and varied roles carried out and the plurality of employers (ibid. p.2).

followed by a call by the RCN and various other professional bodies, including the Council of Deans for regulation of the assistant grades.

Conclusion Part I.

Part I has been presented in two chapters, chapter one conceptualized the RN role into four eras, based on the author's understanding of 'landmarks' which either facilitated or attempted to curtail the RN's role development, role expansion and role extension. Chapter two used the same four eras to provide an overview of the labour force deemed assistants to the RN. Currently there exists a complex mixture of RNs and assistants forming the nursing labour force in NHS hospital wards. The balance between skilled RNs, semi / un-skilled and un-regulated assistants is an enduring one, in the main due to there being no statutory stipulation as to what constitutes 'nursing work', thus 'nursing work'

could be described as a contestable concept, and the work of the RN as 'arporeal'.

To understand the present position of the RN in the hospital it is useful to look from a different vantage point. The 88 years of the SRN / RGN / RNA four eras conceptualised in Chapter One, are now (re) presented as three legislative eras, shown in Table 13.

Table 13: The three legislative nursing eras.

| Legislative Era | 1 | 2 | 3 |
|------------------------------|--|--|--|
| Governing Body | The GNC | The UKCC and the four national boards for education. | The NMC |
| Dates | 1919 - 1984 | 1984 - 2002 | 2002 - Present |
| Descriptor of Nursing | Traditional Nursing | Modern Nursing | Post Modern Nursing |
| Nurses Title | SRN | RGN / Adult RN | RN |
| Pay / Grade | Whitley / Salmon | Clinical Grading A - I | Agenda for Change 1-9 |
| Assistants | General Student Nurse. Orderlies. Nursing Auxiliaries (NA). SEAN. | Support Worker. HCAs. EN. | Band 1-4 non medical personnel. 'Others'. |
| Student Nurse | | 'Adult' Student Nurse - supernumery to the labour force. | 'Adult' Student Nurse - supernumery to the labour force. |

Each legislative era resulted in a change to the RN and Assistants title, training and pay. Legislative Era 1 commenced when the GNC came into being and was referred to as the 'Traditional Nursing Era', and lasted up until the 1979 Nurses, Midwives and Health Visitor Act, out of which came the UKCC and commencement of legislative era 2. The UKCC and their four national boards for education put in place structures that fully modernized the nursing profession. Legislative Era 3 commenced with inception of the NMC, and thus from 2002 began the Post Modern Nursing era. Comparing clinical grading (A-H) with the new Agenda for Change (1-9) it is possible to see the post modern era has

created a re-structuring of health care grading and titles, shown in table 14, which indicates the creation of four grades of 'assistants' where previously there were two.

Table 14. A comparison of clinical grading and Agenda for Change (Hospital).

| Clinical Grading | Practitioner Descriptor | Agenda for Change | Practitioner descriptor |
|-------------------------|---|--------------------------|--|
| I / H | Directorate Nurse Manager. | 9 | *More Senior Staff eg Chief Nurse |
| G | Senior Ward Sister. | 8 | *Consultant Practitioner |
| F | Junior Ward Sister. | 7 | *Advanced practitioner eg Ward Manager / Specialist Nurse. |
| E | Senior Staff Nurse. | 6 | *Senior / Specialist practitioner eg Primary Nurse / Ward Sister. |
| D | Junior Staff Nurse. | 5 | *Practitioners eg Ward based Staff Nurse |
| C | Enrolled Nurse. | 4 | *Assistant / Associate Practitioners |
| B | Auxilliary / orderly / HCA / Receptionist. | 3 | *Senior HCA / Technicians |
| A | | 2 | *Support worker |
| | | 1 | *Domestic /cadet |

* denotes the term used in AfC.

Part II: Methodology.

Part II is a single chapter which explores the methodological decisions made, along with the experiences I had when conducting this ethnographic study. The chapter commences with an account of why ethnography was appropriate for studying the Registered Nurse role within an Acute Trust. Wolcott's (1994) data collection methods, utilised throughout fieldwork are then described, followed by an account of how the ethnographic data was managed. The chapter concludes with an explanation of the ethnographer's approach to conducting an ethical and trustworthy study.

Chapter 3: The empirical approach: ethnography.

Ethnography was used in this study to inductively build an interpretation of surgical RN role development, role expansion and role extension within the Acute Trust Hospital setting. Ethnography as a research methodology in Nursing and Health Care can be applied in numerous ways (Salvage 2000), with some Nurse writers contrasting ethnography in Nursing to that in a subject discipline, suggesting the goal of ethnography in Nursing is to go beyond just understanding, as it should lead to advances in nursing science (Muecke 1994) and improvements in practice (Holloway and Wheeler 2002). Although, Hammersley and Atkinson (1995) caution, if the primary goal of ethnographic research is to change, there is a risk of distorting the findings. Bruni (1995), a nurse researcher, suggests the traditional conventions of ethnographic research are beginning to be challenged by those within nursing, by practitioners considering the social and political foundations of dialogue. These observations are supported in recent studies of clinical nursing which indicate a rejection of some premises surrounding conventional ethnography through asserting knowledge is political, with ethnographic studies in nursing demonstrating a move from an interpretive to a critical stance. In nursing and health care today a range of 'types' of ethnographic studies exist, namely critical ethnography (Street 1992; Thomas 1993; Resnick 1996), institutional ethnography (Townsend 1992; Savishinski 1993; Campbell, Copeland and Tate 1998; Hak 1998), as well as conventional ethnography (Holland 1993; Allen 1996). Use and justification of ethnography are thus marked by diversity rather than consensus.

Some writers have attempted to impose order through classifying the complex landscape referred to as 'types' of ethnography (Hymes 1978; Spradley 1980; Werner and Schofeld 1987), regardless of these classifications and the fact many sub-types of ethnography have evolved from different theoretical orientations, for example: symbolic interactionism, feminism, ethnomethods and

phenomenology. Cresswell (1998) proposes authors be explicit about the type, or school of ethnography they espouse.

This study is a 'single community' (Spradley 1980, p.30), and a 'topic-oriented' (Hymes 1978) ethnography. Single community ethnographies are midway between a macro and a micro ethnography (Spradley 1980), thus classified because the study comprised RNs in one clinical directorate, an organisational / social unit of an Acute Trust hospital. Through delineating the focus of the study to the RN's role the study is 'topic oriented' (Hymes 1978).

Ethnography as methodology in this study.

Ethnography as methodology can be distinguished from other forms of qualitative research by its central focus on culture (Wolcott 1994), defined as 'the learned social behaviour or way of life of a particular group of people' (Germain 2001, p.278). The assumption underpinning selection of the ethnographic approach for this study is that 'any human group together for a period of time will develop a culture' (Patton 1990, p.92), 'creates its own reality or shared culture' (Holland 1993, p.1461), hence creation and performance of a culture is not individual, but a shared social activity, providing individuals with a sense of social /cultural identity. Cultural identity comprises ideational and materialistic dimensions (Fetterman 1998), more simply expressed culture informs what people think (the ideational view of culture) and what people do (the materialistic view of culture). Both ideational and materialistic dimensions of cultural identity formed the lens through which this ethnographer explored RNs' role development, role expansion and role extension. Within a changing, modernizing NHS Edwards (2007) proposes ethnography is an empirical method particularly pertinent for studying 'the experience of work at the point of production' (p.19), and that such systematic observation can reveal important information on labour market experiences of employees and the ways in which managerial controls are deployed.

Ideational views of culture orientated the ethnographer to explore and elicit the RN's cultural knowledge, which Spradley (1980) acknowledged exist on an explicit and tacit level, where explicit cultural knowledge is communicated with relative ease, whilst tacit cultural knowledge lies outside the individual's awareness, a situation referred to in ethnography as the 'taken for granted' aspects of a cultural group's life (Spradley and Mann 1975). Explicit and tacit cultural knowledge was in this study revealed through speech, the primary means for transmitting cultural identity from one generation to the next. Through adopting an ideational orientation to culture in this study surgical RNs as a cultural group were able to define their reality, the meaning of their work and the symbols associated with role expansion. The materialistic view of culture orientated the ethnographer to focus on surgical nurses' observable patterns of behaviour, customs and ways of life (Harris 1968). Through adopting ideational and materialistic cultural dimensions in this study the ethnographer was able to reveal not only what RNs did but what they thought, a practice Spradley (1980a) sees as providing the essential ingredients for a comprehensive ethnographic methodology:

you can easily see behaviour and artifacts but they only represent the thin surface of a deep lake, beneath the surface, hidden from view lies a vast reservoir of cultural knowledge ... our culture has a large body of shared knowledge people learn and use to engage in behaviour and make use of the artifacts connected with it, although cultural knowledge is hidden from view it is of fundamental importance as we all use it constantly to generate behaviour and interpret our experience (p.6).

In addition to focusing on culture, ethnography assumes an holistic orientation (Laughnerne 1995) through context preservation (Germain 2001), context dependence (Mishler 1979) or what Cresswell (1998) calls a context bound approach, as opposed to context stripping (Mishler 1979), a feature of positivist research. In ethnography context preservation acknowledges the need for an ethnographer not only to describe what individuals know and do but 'understand why that behaviour takes place and under what circumstances' (Boyle 1994, p.162). A cultural group's identity derives through a socially constructed source

of knowing which operates continuously and results in a generally shared social perspective. The social forces in operation within a social / cultural setting exert indirect influences on individuals' behaviour and are a layer of context that often goes unrecognised unless it is intentionally sought (Hinds, Chaves and Cypress 1992). Although changeable, these social forces are unlikely to show considerable sudden change. Context was preserved through focusing on surgical nurses as a cultural group, where their role was deemed to have been influenced by the management's response to rising demands for surgical services and by general developments in the nursing profession, what Fetterman (1998) refers to as 'the broader context' (p.20) necessary to get a policy perspective.

Ethnography is also described as a naturalistic inquiry method (Leininger 1987; Baillie 1995a; Hammersley and Atkinson 1998) and one described by Schwandt (2001) as a particular methodology where emphasis is placed on understanding and portrayal of social action from the actor's perspective, an understanding that was achieved in this ethnography through first hand, eyewitness accounts of 'being there' conducting 'fieldwork' in the surgical milieu. Through fieldwork the ideational and materialistic dimensions of the surgical nurse culture were able to be explored at the same time as being able to obtain the contextual dimensions of the surgical nurses' cultural identity, through obtaining data by 'first hand' methods, an approach supported in the writings of Leininger (1987):

greater accuracy and more consistent and meaningful accounts can be obtained by use of naturalistic inquiry modes ... by use of ethnomethods, researcher seeks to get in-depth cognitive knowledge and patterned life experiences by the informant's language use, beliefs, values and actions within the informant's familiar environmental context (p.18).

Role development, role expansion and role extension were deemed in this study to be social phenomena learned and shared among the RNs, and as such able to be 'described and understood' (Morse 1992). Through conducting fieldwork focusing on the cultural and context preservation features of ethnography, the ethnographer was able to describe the shared system of meaning often

described as nursing's cultural system in relation to role development, role expansion and role extension.

The research site and surgical nurses.

After focusing the study on the Registered [surgical] Nurse the next step involved selection of a research site to conduct fieldwork. Since the Conservative white paper Working for Patients (DOH 1990), NHS District General Hospitals (DGH) became Acute Trusts with the operational level of clinical care becoming the 'clinical directorate'. A Clinical Directorate was selected because it is an organisational unit / social situation (Spradley 1980) essential for contextualising data as role development, role expansion and role extension can be managerially led or triggered by practitioners themselves. Studying a social unit allowed the ethnographer to experience management messages received by surgical nurses, and to experience surgical nurses' day to day practice and their responses to management messages through having access to the Directorate's organisational machinery and the surgical nurses.

In my role as a University Lecturer I had forged links with four Acute Trusts General Surgery and Urology Clinical Directorates, from which I had to select one to conduct fieldwork. The selection process began with locality studies during which three issues emerged. Firstly, in one Acute Trust I had recently held a seconded Senior Nurse Manager position responsible for Nurses' role expansion, therefore I felt it inappropriate to choose this Trust as key informants may have viewed me as a practitioner in a previous role, which could draw into question the study's reliability and validity, a declaration of interest which reduced my choice to three hospitals. Secondly two hospitals had replaced a large proportion of the RN labour force with NVQ prepared Health Care Assistants (HCAs) as a result of the implementation of Project 2000, and both Trusts explained they were experiencing difficulties retaining RNs, therefore relying on a transient workforce made up of agency staff, a situation

which would have posed difficulties during fieldwork where continuous access to key informants is a feature of ethnography. The final Clinical Directorate was operating a nursing labor process described as Primary Nursing⁶⁹, which was chosen to collect the empirical data, and comprised six surgical wards and five specialist surgical nursing services.

Ethnographers study populations of people (LeCompte and Schensul 1999). To identify the population in this study an operational definition was identified as 'RNs with permanent employment contracts within the surgical directorate', a definition devised to avoid recruitment of members of the transient nursing workforce comprising Student Nurses, Agency staff and Overseas Nurse recruits⁷⁰, who are regularly found on NHS surgical wards. Details of the permanently employed surgical RNs were provided by the Directorate Nurse Manager (DNM). The population of RNs at the beginning of the study was 127, soon after commencing fieldwork twelve newly Registered RNs were appointed into vacant positions, these were recruited to the population as their behavior and thoughts regarding role development, role expansion and role extension during the first year of registration would provide a valuable insight into the surgical nurse role.

The total population of RNs was 139, who were classified into four theoretical samples (Baillie 1995a): Surgical Ward Nurse Managers, Ward based Senior Surgical Nurses (Primary and Associate nurses), Ward based Junior Surgical Nurses and Specialist Surgical Nurses (ANPs & CNSs⁷¹). Through sub classifying the population, fieldwork was planned to experience and gain insight into the working lives of the four groups of RNs to achieve adequate coverage of the research topic (Hammersley and Atkinson 1998).

⁶⁹ **Primary Nursing:** considered within the nursing profession to be the 'gold standard' approach to organizing the nursing labour force in hospital wards, comprising a higher ratio of RNs to nursing assistants.

⁷⁰ **Adaptation Nurses:** Overseas recruits required to undertake a Nurse adaptation programme.

⁷¹ ANPs – Advanced Nurse Practitioners, CNSs – Clinical Nurse Specialists.

Getting my foot in the door: the survey period.

During the three month period obtaining ethical approval I used my legitimate Senior Lecturer role to commence the process of constructing a profile of the Acute Trust⁷². The prime aim of the survey period was to get myself known, find out about shift patterns, clinics, operating theatre sessions and generally gather data on the Acute Trust, a task seen as essential for ethnographic contextualisation. Looking back at this 'survey period', it was a phase in the ethnographic process Fetterman (1998) describes as 'learning the basics'. Table 15 outlines the data retrieved and the sources from which it was obtained.

Ethnographic fieldwork.

Ethnographic fieldwork progressed through Spradley's (1980) descriptive, focused and selective phases. During the descriptive phase the ethnographic focus remained broad to ensure the breadth of RN practice was explored. The focused phase comprised a more careful study of the four groups of Surgical RNs in relation to themes elicited from analysis of the fieldwork data obtained during the descriptive phase. The final selective phase was spent validating the ethnographically derived themes and conducting ethnographic interviews.

Throughout fieldwork the researcher engaged in the everyday work of the four groups of RNs on the six surgical wards, and with RNs manning the five specialist nursing services. Fieldwork covered the seven day week and the 24 hour day, including bank holidays. My philosophy of the 'style of being there' with the RNs was as an RN myself, in a 'helper role' based on the feminist ethic 'reciprocity' (Lincoln 1985, p.280). Data collection strategies described by Wolcott (1994) formed the framework for conducting fieldwork, described as experiencing (participant observation), enquiring (interviewing) and examining (studying documents).

⁷² which commenced following presentation of the study at a Senior Surgical Nurse meeting.

Table 15: Trust Profiling: Data retrieved and Sources utilised.

| Data retrieved. | Sources Utilised. |
|---|--|
| <i>The City - Generally</i> <ul style="list-style-type: none"> • General characteristics / Where situated • Population characteristics ie public health profile • Population hospital serves | Local web sites Public Health Report Trust Annual Report Public Library |
| <i>The DGH (Trust)</i> <ul style="list-style-type: none"> • Its history / evolution • Annual Budget • Clinical Services and Regional services • Number and type of employees • Mission, philosophy, objectives • Managerial organisation (generally / nursing) • Factors affecting • Performance indicators | Trust Annual Report Trust web site CHI report and action plan Nursing and Midwifery strategy Trust monthly newspaper Trust medical library archives |
| <i>Surgical Services in the Trust</i> <ul style="list-style-type: none"> • Types of surgical services • Managerial organization • Annual throughput • Operational structures • Communication systems | Trust Annual report Meeting with DNM |
| <i>Division of General Surgery and Urology</i> <ul style="list-style-type: none"> • How evolved / recent changes • What it comprises • Medical staffing • 'On take' rotas • Weekly routines: theatre lists, OPD sessions, pre admission clinics • Managerial structure /Meetings • Shift patterns • Budget / throughput stats • Proposed developments • Problems | Directorate annual report DNM / Business Manager Surgical ward notice boards |
| <i>Individual wards</i> <ul style="list-style-type: none"> • Where located - geographically • Number of beds and layout • Clinical specialties / weekly routine • Establishment / duty rotas • History / current issues | DNM Ward Nurse Managers |
| <i>Specialist Nursing Services</i> <ul style="list-style-type: none"> • How many / where located • Weekly routine • History / current issues | DNM Specialist surgical nurses |
| <i>Additional Information</i> <ul style="list-style-type: none"> • Documents on expanded role | Policy files |

Experiencing: Observation 'through' participation.

My fieldwork role was a process of 'observation through participant', the specific roles I played ranged from complete observer to complete participant (Wolcott 1994), depending on the surgical situation I was experiencing. Fieldwork on surgical wards was conducted with individual RNs and I was part of the Nursing labour force in the system of Primary Nursing. My contribution to the labour process involved working in a bay of six or seven patients using my RN position to experience what it was currently like to be an RN participating in the delivery of direct patient care, nursing handovers, medical ward rounds, ward meetings, supervision of student nurses, interaction with patients' relatives and friends and on some days liaising with the police. In the role of observer many insights were gained from sitting at the nursing station which allowed me to experience Nurse to Nurse interactions, listen to telephone conversations, note relationships between medical staff and RNs and listen to personal tales. Very little pure observation was embarked on as there were always plenty of things to talk about and participate in.

I often adopted a 'shadowing role' (Allen 1996, p. 169) when with the most senior RNs, which allowed access to otherwise inaccessible clinical situations, for example impromptu and formal meetings with non clinical and clinical managers, dealing with complaints, negotiating surgical patient admissions, discharges and transfers, the giving of bad news and many more activities in the domain of senior RNs and often conducted backstage. Key events (Spradley 1980, p.41) often occurred in the surgical milieu, for example inadequate beds for the number of surgical patient admissions, staffing problems and clinical emergencies, each of which provided an opportunity to witness how RNs dealt with complex clinical scenarios and the repercussions following them.

Numerical data played a significant role in the surgical nurses' day to day activities, in the form of admission and discharge data, patient dependency,

incidence and type of complaints, monthly staffing levels and budgetary data. In view of numerical data playing such an important part in the RN's working life I too made records of this, with the aim of illustrating aspects of surgical life in this ethnography.

A central process in ethnographic studies is the identification of key informants, people able to give insight into the phenomena under study (Mackenzie 1994), who were identified based on emergent findings. For example several RNs had additional dimensions to their ward based direct patient care role, like running pre admission surgical services, whilst another Primary Nurse spent two days a week performing the role of clinical skills facilitator with newly appointed RNs. Once key informants were identified I worked with them to experience their specific role expansion activities, a process referred to as 'sampling activities and events' (Mackenzie 1994, pp.777-779). A composite list of surgical nurse activities I participated in and observed during fieldwork is shown in Figure 36.

Enquiring: questions, conversations and interviews.

To reveal explicit and tacit dimensions of cultural knowledge a number of enquiry tactics were utilized, because as Harris (1976) suggests 'the way to get inside of people's heads is to talk to them, to ask questions about what they think and feel' (p.331). Interviewing was used throughout fieldwork in the form of spontaneous, informal conversations (Hammersley and Atkinson 1998) to more formally arranged, in-depth interviews related to fieldwork observation, fieldnotes and data analysis.

Two focus groups were used as enquiry techniques, the first during the induction week for the newly employed, newly registered RNs where I was able to elicit thoughts and feelings about their pending career in the surgical milieu.

Figure 36: Surgical Nurse activities observed and participated in.

Ward based direct patient care activities.

Performing clinical observations eg Blood pressure, pulse, respiratory rate, pulse oximetry, temperature
Fluid balance recording
Meeting patients' hygiene needs
Mobilising patients
Meeting patients' elimination needs
Meeting patients' fluid and food needs
Admitting and discharging surgical patients
Doing clinical procedures eg insertion of naso gastric tubes, dressings, urinary catheterization
Transferring patients to high dependency and intensive care units
Accompanying surgical patients to and from the operating theatre

Assisting medical staff.

Assisting medical staff perform clinical procedures eg Lumbar puncture, chest drain insertion
Chaperoning medical staff attending patients
Attending Consultant, Senior Registrar and Registrar ward rounds

Ward based managerial activities.

Doing the monthly budget and staffing data for senior managers
Planning the duty rota
Ward stocking
Answering the telephone
Daily checking procedures eg resuscitation equipment, fire equipment etc.

Away from the ward managerial and educational activities.

Monthly Senior Surgical Nurse meetings with DNM / Modern Matron
Business Manager - backstage role and responsibilities
Care pathway working group
The work of the DNM / Modern Matron - investigating complaints, staff selection and appraisal.
Staff nurse induction programme.

Away from the ward - with ward staff (direct patient care activities).

Pre-admission clinics
Home visits
Working with RNs in the out-patient department,

Specialist Nursing Services.

Home visits
Nurse led clinics
Office work / administration (data processing / report writing)
Cancer network meetings
Multi Disciplinary Meetings (MDT) for cancer patients

Eleven of the twelve RNs trained locally and I was given access to their training transcripts to identify the curriculum they followed in relation to surgical theory and practice. The other, frequently used focus group was the monthly Senior Nurse meeting where I gave an update on my developing ideas, during which Senior Nurses clarified issues, which were recorded as fieldnotes.

Towards the end of the 'selective' phase of fieldwork cultural themes evolved related to the RN's role. These themes formed the basis of the ethnographic interviews with twenty key informants, five from each of the four groups of RNs employed in the surgical directorate. Each tape-recorded ethnographic interview lasted between 1 - 2 hours. When conducting the ethnographic interviews many RNs saw this as an opportunity to talk about themselves and nursing, opportunities many said no longer existed due to their demanding workload. Sensitive issues frequently arose within interviews and I found myself sharing personal nursing experiences, an occurrence feminist researchers acknowledge as one of the complexities of the in-depth interviewing process (Sorrell and Redmond 1995; Holloway and Fullbrook 2001).

Examining: the use of documentary evidence.

A monumental amount of organisational literature was retrieved during fieldwork, listed in Appendix 15. Some literature proved useful at the time of its retrieval, for example the list of surgical ward shift patterns which ensured my punctuality, others have been more useful during the different phases of data analysis.

Whilst data collection strategies have been reported separately above, the reality was the strategies occurred simultaneously. Whilst in the field I undertook observation, but this rarely occurred without conversation (interviewing) and my participating in the surgical nurses' daily lives. Documents pertinent to fieldwork were retrieved there and then, and often formed the basis of a conversation with the RNs.

On completing the study I am able to calculate I spent 60 hours over three months conducting the survey period, and 500 hours over fifteen months, conducting fieldwork as an RN. The number of RNs who participated in the study is estimated as 100.

Management of the ethnographic data.

Data management is described by Huberman and Miles (1994) as the 'systematic, coherent process of data collection, storage and retrieval' (p428). What is reported here are two ethnographic data management processes, first is the recording and processing of ethnographic records, and second are the ethnographic data analysis processes.

Recording and processing the ethnographic records.

As pointed out by Emerson, Fretz and Shaw (2001) ethnographers are not only explorers, but also scribes (pp.352-368). In view of this observation and mindful of the fact 'memory fades quickly' (Fetterman 1998, p.114) and details could have easily been lost (Hammersley and Atkinson 1995), from the beginning of fieldwork I recorded my experiences and conversations. I adopted an 'in the field' style of notation in the form of open notation into a spiral bound notebook, recording not only what was observed, but what was said (verbatim where possible), the questions I asked and the responses received. I also recorded emerging questions, short phrases and keywords to act as memory joggers to aid the process of transcription following fieldwork, and to assist in the next fieldwork episode. A concern for context preservation was integral to the analysis process (Leininger 1987), so following each fieldwork session the context under which the ethnographic data was generated was noted on a 'contact summary sheet' (Miles and Huberman 1994, pp.51-54), to facilitate what Fetterman (1998) describes as thinking meaningfully about data (p.93), and the first and most important stage of analysis.

All fieldnotes and tape-recorded data were transcribed into an A4 fixed page journal. The transcription process led to my expanding on events and activities experienced in the field, and I preserved the verbatim speech provided by surgical nurses to minimise inference by myself (Hammersley and Atkinson 1995). Each day's transcribed fieldnotes were word-processed and checked for accuracy against the handwritten notes. Organisational literature retrieved during a period of fieldwork were listed at the end of the word-processed fieldnotes, the organizational literature was then archived with the original fieldnotes. An example of word-processed fieldnotes is shown in Appendix 16.

Tape recorded ethnographic interviews were transcribed verbatim, a technique Hammersley and Atkinson (1995) refer to as preserving situated vocabularies:

actual words people use can be of considerable analytic importance ... the situated vocabularies employed provide valuable information about the ways members of a particular culture organise their perceptions of the world and so engage in the social construction of reality, situated vocabularies ... incorporate the typifications and recipes for action that constitute the stock of knowledge and practical reasoning of the members ... an important task is to be able to retrieve the actual contexts of use for such folk terms ... this is dependent on the delicacy of ethnographic data ...so social context can be identified with precision (pp.182-183).

Each transcribed, word-processed interview was checked for accuracy through listening to the taped interview and checking it with the transcription, a sample is shown in appendix 17. Additionally a fieldwork journal was maintained as a daily diary on commencing the study, after contacting gatekeepers' entries in the journal expanded to include memorandum, described by Hammersley and Atkinson (1995) as 'promising analytic ideas' (ibid. p.191). As fieldwork intensified and data analysis became a key part of the transcription process ethnographic records evolved into an increasing number of analytic notes. The construction of analytic notes and memorandum are what Hammersley and Atkinson (1995) see as the essence of reflexive ethnography:

One is forced to question what one knows, how such knowledge was acquired, the degree of certainty of such knowledge and what further lines of inquiry are implied (p.192).

Since completing fieldwork the ethnographic records have been increasingly valuable in constructing the thesis, a feature Fetterman (1998) supports when he wrote:

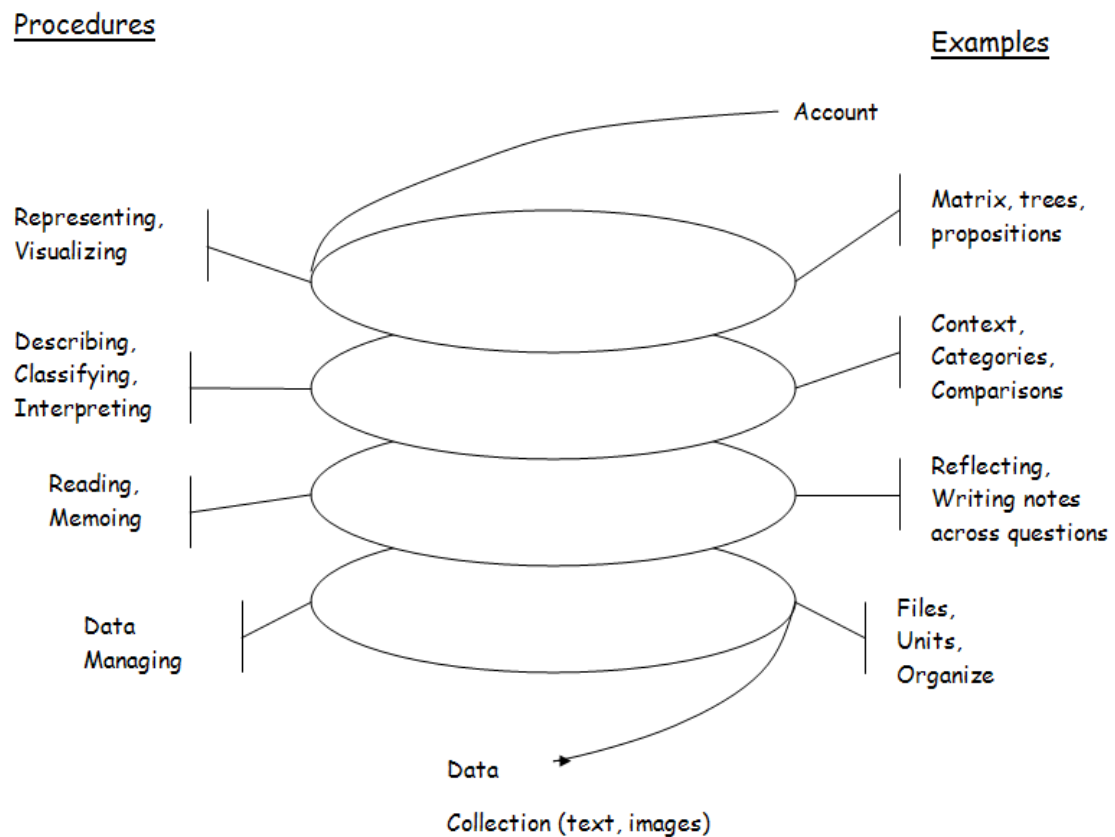
Writing memorandum throughout a study also makes report writing much easier. The ethnographer can draw introductory and background sections from the proposal that was modified after the field experience. The core of the report then comes directly from memorandum and feedback generated throughout the study. Thus, the ethnographer needs only to finish the final synthesis, which explains how all the memorandum and the responses fit together (p.117).

Ethnographic data analysis.

Data collection and analysis occurred simultaneously in this ethnographic study (Hammersley and Atkinson 1997, Fetterman 1998) corresponding with Spradley's (1980) three phases of fieldwork: descriptive, selective and focused. Between the descriptive and selective, and the selective and focused phases of fieldwork 'time out' periods were allocated where ethnographic data analysis was more concentrated (as opposed to being diluted by continued fieldwork). The aim of these concentrated periods was 'crystallisation of the data', a process Fetterman (1998) suggests leads to 'insights spontaneously striking the ethnographer' (p.108).

Creswell's (1998) qualitative data analysis spiral formed the broad framework for analysing the initial data. Analysis occurred through a process of analytical circling where the researcher entered a cycle of reading and immersing herself in the ethnographic records, followed by a cycle of describing and classifying data, shown in figure 37. As Creswell's (1998) data analysis spiral provided only general guidelines for analysing qualitative data, additional data analysis techniques were used during the three phases of ethnographic fieldwork, this eclectic application of data analysis techniques is expected in ethnographic studies, as each study has unique characteristics (Hammersley and Atkinson 1995).

Figure 37: Creswell (1998) Data analysis spiral.



Analysis processes are broadly aligned to Spradley's (1980) phases of fieldwork and Wolcott's (1994) data analysis phases, modelled in Figure 38, and now described in more detail.

Figure 38: Fieldwork and data analysis phases (Spradley 1980; Wolcott 1994).

| Spradley (1980) Phases of Data Collection | Wolcott (1994) Transforming qualitative data. |
|--|--|
| Descriptive | Description |
| Selective | Analysis |
| Focused | Interpretation |

Ethnographic data analysis at the 'descriptive' phase of fieldwork.

This period of fieldwork was where the ethnographic focus remained broad, Creswell's (1998) first analytic circle was applied to word-processed fieldnotes and context summary sheets through reading and re-reading to allow immersion

in the data (Agar 1980; Creswell 1988). Immersion in the data led to identification of descriptive concepts (Hammersley and Atkinson 1995) which were recorded in the data based fieldnotes and interview transcripts, a process also described as 'tagging text' (Ryan and Russell Bernard 2000, p.782) shown in Appendix 18. At the end of tagging all fieldnotes during this phase of fieldwork, descriptive concepts for each set of fieldnotes were summarized, a process likened to 'building a codebook' or indexing (Ryan and Russell Bernard 2000, p.781) shown in Appendix 19. Key events were extracted from fieldnotes and analysed to identify RNs' actions related to managing the key event, a process Fetterman (1998) describes as 'providing a lens through which to view a culture' (p.99); the outcomes were recorded as cultural practices, these were then fleshed into stories.

On completion of the descriptive phase of fieldwork a two week 'time out' period took place during which ethnographic records were re-read and descriptive concepts checked to see if they remained appropriate in light of my deeper understanding of the surgical nurse milieu. Analysis then progressed into what Wolcott (1994) described as 'patterned regularities', what Leininger (1987) calls 'recurrent and special themes in context' (p.31), achieved through comparing information sources to support or refute tentative findings. Descriptive concepts were sorted and grouped into a smaller number of sets (Roper and Shapira 2000) through the use of map making, which are visual representations of a community

Which forces the ethnographer to abstract and reduce reality to a manageable size, it crystallizes images, networks and understandings and suggests new paths to explore (Fetterman 1998, p.101).

The process of clustering by conceptual grouping through map making led to the development of 35 themes related to the RN's role listed in Appendix 20, these themes were word-processed and descriptive concepts related to each theme identified, two examples of themes with their corresponding descriptive concepts are shown in Figure 39.

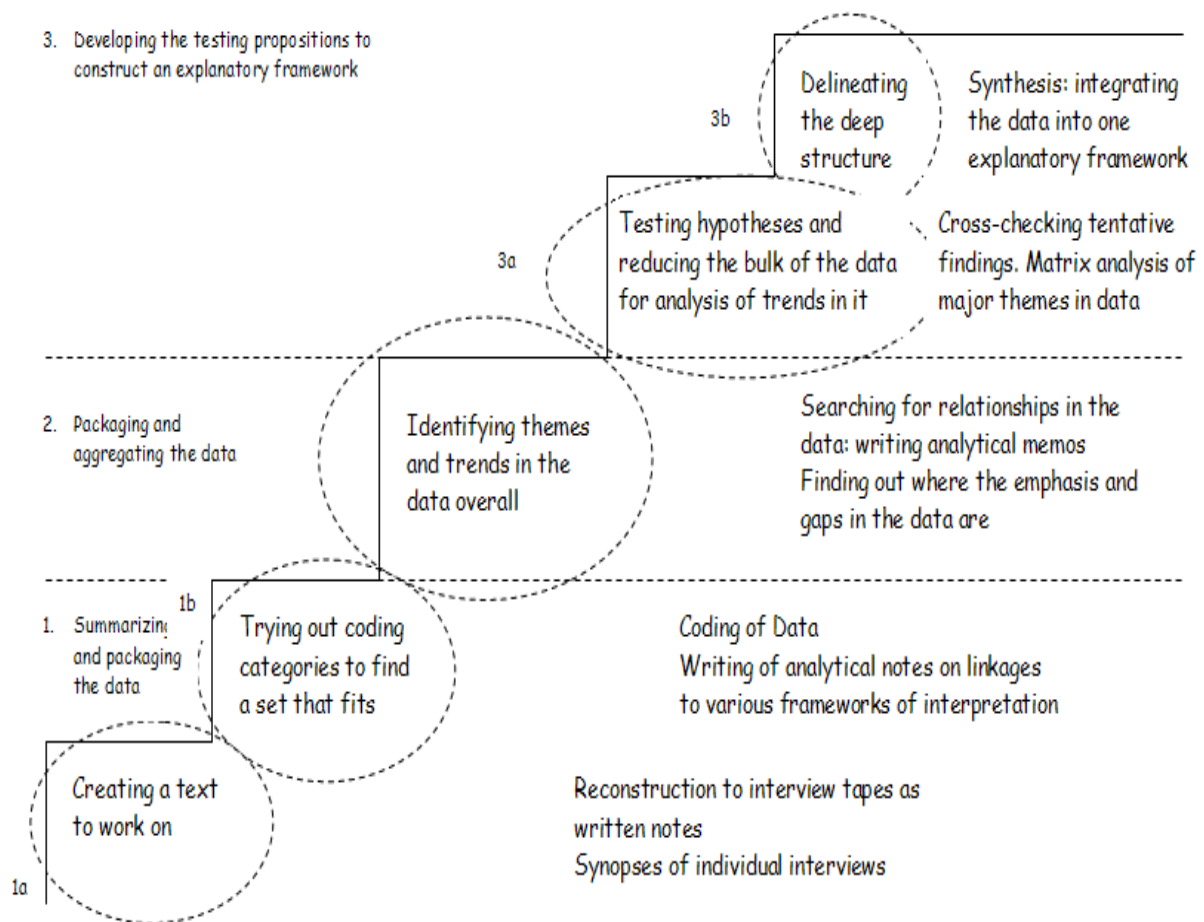
Figure 39: Two cultural themes and associated descriptive concepts.

| | |
|------------------------------|---|
| Theme: | <i>Boundary Disputes</i> |
| Descriptive concepts: | Blurring of roles Don't know their place Antagonisms They wouldn't do our bed baths Bladder scanning beyond a joke Blame culture Confusion of roles and responsibilities Bloods - who decides / who follows up results Nothing on paper |
| Theme: | <i>Surgical nurse knows best 'Persistence'</i> |
| Descriptive concepts: | Calling Doctors Stopping inappropriate discharge Demanding resuscitation status reviewed Ringing consultant direct Listening to the patient Not giving prescribed drugs |

Ethnographic data analysis at the 'selective' phase of fieldwork.

This phase of fieldwork involved a more in-depth study of the four groups of RNs in relation to the 35 themes elicited from the descriptive phase of fieldwork. Data analysis continued through reviewing fieldnotes, tagging them with descriptive concepts and marking texts for meaning related to the 35 themes. As fieldwork progressed pattern coding was utilized, where descriptive concepts and cultural themes were grouped and collapsed into a smaller number of themes, a complex stage in qualitative analysis (Miles and Huberman 1994). The specific technique of 'role ordered display' (Miles and Huberman 1994, pp.122-127), helped make sense of the roles of the four groups of RNs. Mapping aided the process of moving analysis from describing to explaining the culture sharing practices of RNs, where themes and trends in the overall data were identified and hypotheses were tested through a process of cross-checking data sources, a process Miles and Huberman (1994) refer to as moving up Carney's (1990) ladder of analytic abstraction shown in Figure 40.

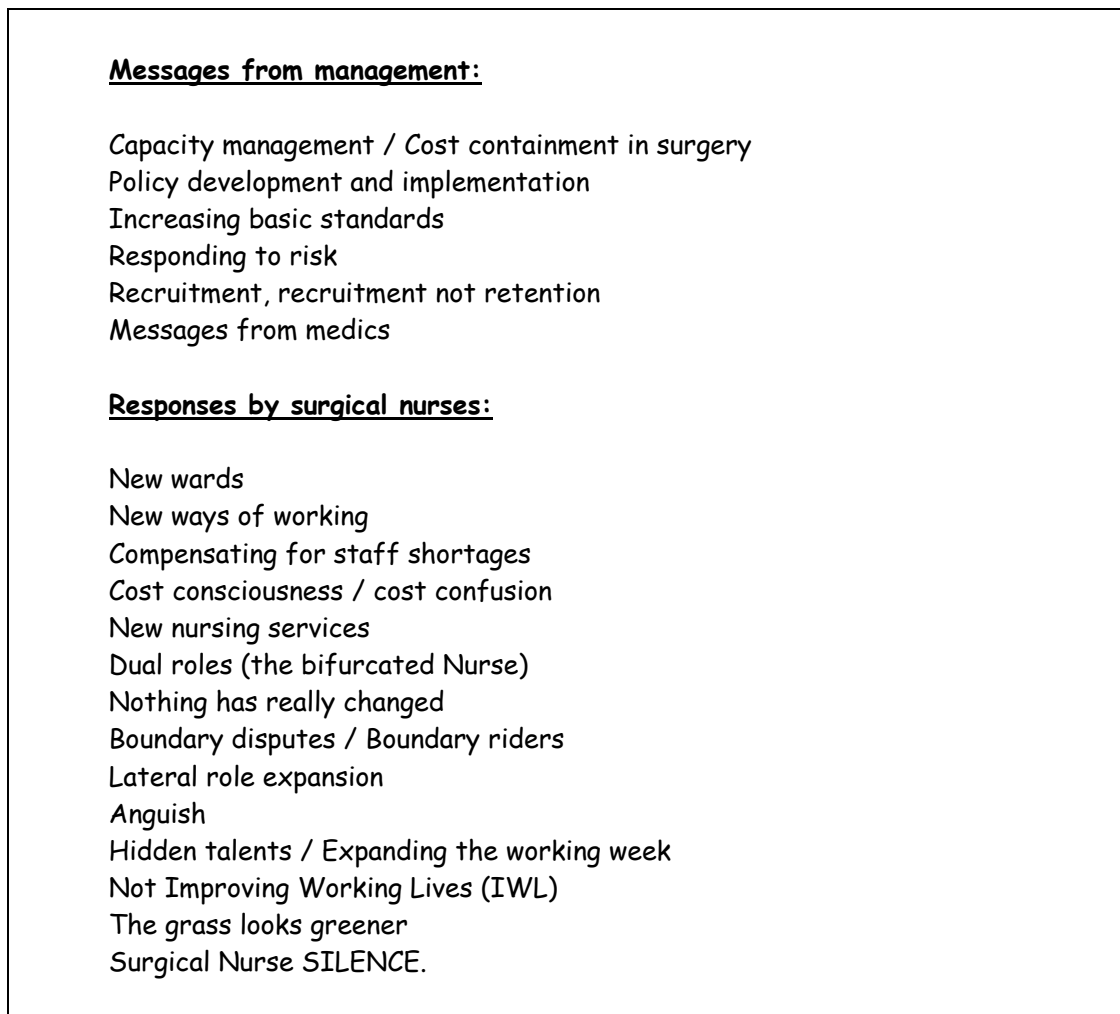
Figure 40: Ladder of analytical abstraction (Carney 1990).



Negative cases were identified and hypotheses revised through a process of recursive analysis (Ryan and Russell Bernard 2000) which led to the accommodation of data that did not fit into the general schema of current analytic insights, from which a set of inductively derived cultural themes / abstracted concepts evolved (Ryan and Russell Bernard 2000), and an increasing number of descriptive and analytical memorandum.

A framework for organising the inductively derived themes related to the RN's role was then constructed based on the concepts 'messages from management', and 'responses by surgical nurses' shown in Figure 41, culminating in a structure for the focused and final phase of fieldwork.

Figure 41: Framework for conducting the ethnographic interviews.



Ethnographic data analysis at the 'focused' phase of fieldwork.

This period of fieldwork was spent validating cultural themes and undertaking ethnographic interviews. Ryan and Russell Bernard's (2000) whole text analysis was used to review transcribed interviews, and was conducted in the sociological tradition of marking interview texts for meaning related to cultural themes discussed during the in-depth interviews, one mind map was then created for each surgical nurse interview shown in Appendix 21.

Mind maps were then grouped by surgical nurse type for example junior, senior, in-between, and a process of 'constant comparison' (Hammersley and Atkinson 1995) took place. Analysis also involved organisational literature, this was reviewed depending on the nature of the interpretation required, for example

twelve Acute Trust newspapers (monthly publications) were subjected to content analysis (Fetterman 1998) to identify references to the surgical directorate and surgical nurses. Monthly staffing data was entered onto spreadsheets to create descriptive statistics to allow the identification of trends related to staffing changes over the period of fieldwork. An overview of the ethnographic data analysis process is shown in Appendix 22.

Construction of the 'cultural inventory'

One final review of all ethnographic data was deemed essential as much can be forgotten in the process of analytic progression (Miles and Huberman 1994). All themes and descriptive concepts emanating from the ethnographic endeavour were checked with the ethnographic data, through comparing and contrasting themes and descriptive concepts with fieldnotes and interview transcripts. Once I was satisfied themes were saturated, and there were no additional explanations for these, all fieldwork data, interview data, memorandum, analytical insights and interpretations were aggregated into 'a cultural inventory' (Spradley 1980, p.155), shown in Table 16, an alphabetical index which enabled ease of retrieval of all data in preparation for interpretation and production of the ethnographic report.

Table 16: Final cultural inventory.

| Theme / Category | Supplementary Themes / categories |
|---|--|
| Absorbing DOH / Trust agendas | |
| Acting Up | |
| Agency Nurses | |
| All is not happy | |
| Anguish / stressed | |
| Architectural boundaries | |
| Associate Nurses | |
| Backfilling | |
| Bed Management | To Come In (TCI), Getting patients in |
| Being consulted | |
| Boundary Disputes | Substitution confusion (the top five) |
| Care pathways | |
| Caring for colleagues | |
| Cinderella | |
| Clash of the Titans | Critical care vs: surgical nursing |
| Consultant surgeons | |
| Co-ordinator / nurse in charge role | |
| Coping with the pressures | |
| Critical incidents | |
| Cycle of staff change | |
| Cynicism | |
| D grade / junior surgical nurses | Views of self / of seniors |
| Dependency (surgical patient) | |
| DNM / Modern Matron | |
| Doing more for more with less | |
| Dual roles | |
| Erosion | |
| Extending the working week | |
| Filling over the cracks | Not strengthening foundations |
| Financial issues | Cost containment, reduction, confusion |
| Future role expansion | |
| Going backwards | Nothing has really changed |
| Grass looks greener | |
| Growing your own | Student Nurse / New D |
| Hidden talents | |
| In the interest of patients | |
| IV drugs | |
| Junior Doctors | Diagnosis / prescription. Disputes |
| Knowledgeable doers | |
| Limitations on my role | Role expansion restrictions |
| Management (non clinical) | Philosophy, Messages, Chasm, Policies |
| Marginalization | Including media |
| Medical outliers | |
| Medical students | |
| Night duty / Night Nurse Practitioner (NNP) | |

| | |
|--|--------------------------------------|
| No slack in the system | |
| Nursing Auxiliary | |
| Nursing station diagnosis and prescription | |
| Outreach / MEWS | |
| Other nurses (in the Directorate) | |
| Persistence | |
| Prescribing | |
| Phillipino Nurses | |
| Primary Nursing | |
| Promotion | |
| Providing cover | |
| Pulled further from the patient | |
| Responses to management messages | |
| Role confusion | |
| Role contraction | |
| Role expansion | Generally, Hidden talents |
| Senior surgical nurses | |
| Senior ward nurse role | |
| Shift patterns | |
| Silence | Consensus on the surface |
| Sisters meeting | |
| Specialization | |
| Specialist Nurse services | Upper/lower GI, Breast etc |
| Staffing and skill mix | Staffing, Skill mix |
| Student nurses | |
| Study leave | |
| Support, supervision, surveillance, saturation | |
| Surgical Nursing | |
| Task allocation | |
| Training (cascade) | |
| Wards | |
| Ward nurse managers | |
| Working conditions | Not Improving Working Lives (of RNs) |
| Working to full capacity | Status quo / Paralysis. |

The interpretation process.

Armed with the inductively derived constructs, these were then compared with referent constructs in the literature, a process Wolcott (1994) refers to as the final stage in ethnographic studies, the interpretation of the culture sharing group. The cultural inventory themes, alongside the interpretative frameworks were then subjected to a mapping process prior to writing up the findings shown in Table 17, utilized across Parts III and IV of the thesis, and re-mapped across the remaining chapters of the thesis shown in Appendix 23.

Table 17: Cultural inventory mapped across the remaining thesis chapters.

| Theme. | Part III: Findings | | | Part IV: Interpretation | |
|-------------------------------------|--|--|---------------|----------------------------|--|
| | Ch 4: Hospital and surgical services. | Ch 5: Surgical Nurses and conditions | Ch 6: Role | Ch 7; Responses | Ch 8: 21 st century role. |
| Absorbing DOH/Trust agendas | | | | √ | |
| Acting up | | √ | | | |
| Agency Nurses | | √ | | | |
| All is not happy | | | | √ | |
| Anguish /stressed | | √ | √ | | |
| Architectural boundaries | √ | | | | |
| Associate Nurses | | √ | √ | | |
| Auxilliary Nurses | | √ | | | |
| Backfilling | | | | | |
| Bed management | | √ | √ | | |
| Being consulted | | | | | |
| Boundary disputes | | | √ | | |
| Care Pathways | √ | | | | |
| Caring for colleagues (supportive) | | | | √ | |
| Cinderella | | | √ | | |
| Clash of the Titans | | √ | √ | | |
| Consultant surgeons | √ | | | | |
| Co-ordinator / Nurse in charge role | | | √ | | |
| Coping with the pressures | | | | √ | |
| Critical incidents | | | | | |
| Cycle of staff change | | √ | | | |
| Cynical | √ | | | | |
| D grade / junior surgical nurses | | √ | | | |
| Dependency (surgical patient) | √ | | | √ | |
| DNM / Modern Matron | | √ | | | |
| Doing more for more with less. | | | | | |
| Dual roles. | | √ | | | |
| Erosion. | | | | | |
| Extending the working week | | | √ | | |
| Filling over the cracks | | | | √ | |
| Financial issues | √ | √ | | | |
| Future role expansion | | | √ | | |
| Going backwards | | | √ | | |
| Grass looks greener | | √ | | | |
| Growing your own | | √ | | | |
| Hidden talents | | | √ | | |
| In the interest of patients. | | | | √ | |

| | | | | |
|--|---|---|---|---|
| IV Drugs | | | √ | |
| Junior Doctors | √ | √ | √ | |
| Knowledgeable doers | | | | |
| Limitations on my role | | | √ | |
| Management (non-clinical) | √ | | | |
| Marginalization | | | | |
| Medical outliers | √ | | | |
| Medical students | √ | | | |
| Night Duty / NNP | | √ | √ | |
| No slack in the system | | | | √ |
| Nursing station diagnosis and prescription | | | √ | |
| Outreach / MEWS | √ | | √ | |
| Other nurses | | √ | | |
| Persistence | | | | |
| Prescribing | | | √ | |
| Philipino Nurses | | √ | | |
| Primary Nursing | √ | √ | √ | |
| Promotion | | √ | | |
| Providing cover | | √ | | |
| Pulled further from the patient | | √ | | |
| Responses to management messages | | | | √ |
| Role confusion | | | √ | |
| Role contraction | | | √ | |
| Role expansion | | | √ | |
| Senior surgical nurses | | √ | | |
| Senior ward nurse role | | √ | | |
| Shift patterns | | √ | | |
| Silence | √ | | | |
| Sisters meeting | √ | | | |
| Specialization | √ | | | |
| Specialist nurse services | √ | √ | √ | |
| Staffing and skill mix | | √ | √ | |
| Student Nurses | | √ | √ | |
| Study leave | | √ | | |
| Support, supervision, surveillance, saturation | | | | √ |
| Surgical Nursing | | | √ | |
| Task allocation | | | √ | |
| Training (cascade) | √ | √ | √ | |
| Wards | √ | | | |
| Ward Nurse Managers | | √ | | |
| Working conditions | | √ | | |
| Working to full capacity | | | | √ |

Three additional themes were generated during the interpretation of the data shown in Table 18.

Table 18: Additional themes generated during interpretation.

| Additional Themes | Interpretation Part IV | |
|--|---------------------------|-----------|
| | Chapter 7 | Chapter 8 |
| Double / triple substitution | | |
| Paralysis - neither expansion nor contraction | | |
| Sidling up (reconstitution of the old culture) | | |

Being a moral, ethical RN ethnographer.

Specifically related to ethnography Roper and Shapira (2000) point out 'the crucial imperative [is to] behave morally at all times' (p.123) and a responsibility which lies with the individual investigator. As the study was conducted at a moment in time when ethical scrutiny of research in healthcare reached an all-time high, following publication of the DOH (2001c) Research Governance strategy, it was initially essential to make transparent the moral and ethical principles on which the study was to be conducted. Because I came to the study with a diverse array of ethical experiences directly and indirectly related to nursing research I looked to Denzin and Lincoln (1994) for guidance, they reminded me of the need for qualitative researchers to confront immediately the ethics and politics of empirical inquiry.

Two approaches were adopted to explore the ethical issues surrounding the proposed study. First was a search to identify and endorse the researcher's ethical stance and second was what can best be described as a Holy Grail approach to selecting principles for applying ethical self scrutiny (Hammick 1997) prior to and during the conduct of the research. Both approaches aimed to ensure clarification of the moral and ethical standards on which the study was to be conducted, and the practical application of these as an RN conducting fieldwork; each is now described.

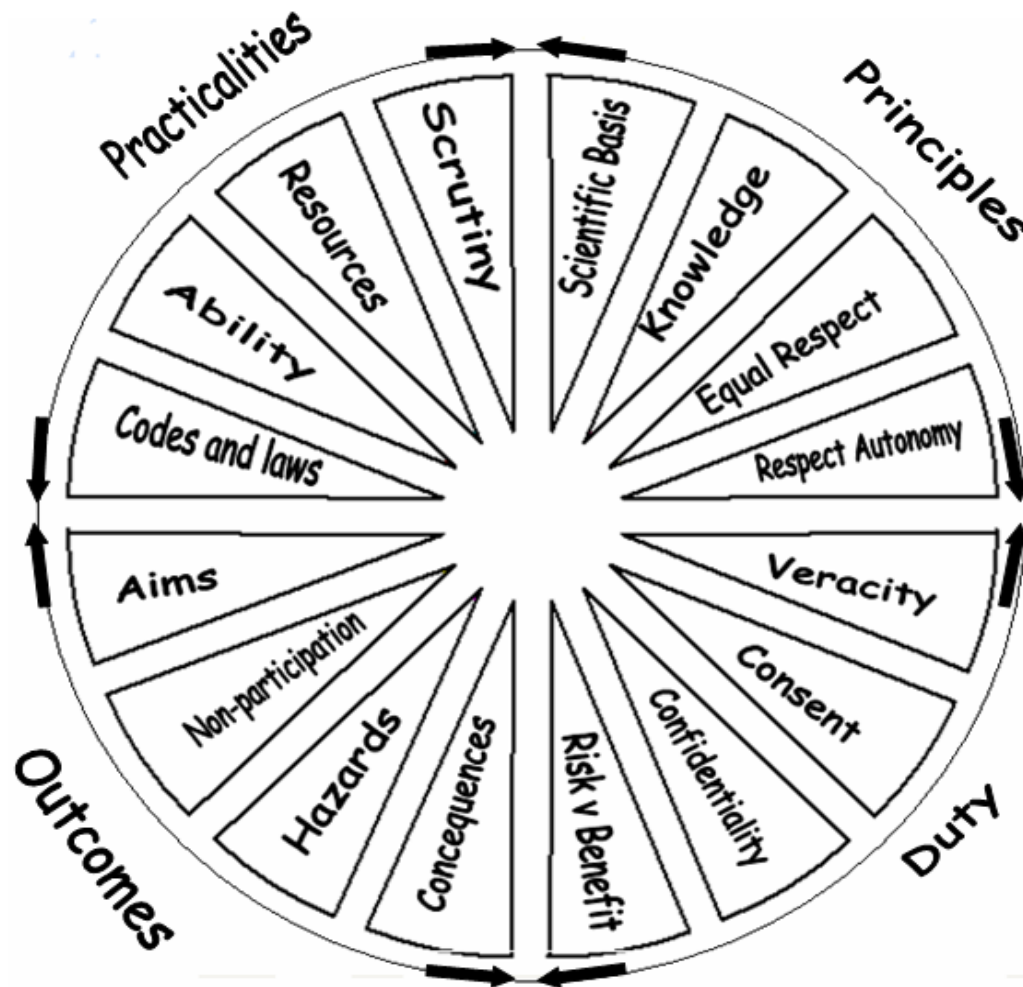
Adopting an 'ethical standpoint' and applying 'ethical self scrutiny'.

The 'contextualized-consequentialist' ethical stance described by Denzin and Lincoln (1994, p.21) was deemed most in line with my own philosophy, assumptions and experience gained through 30 years as an RN. This ethical stance (House 1990, Smith 1990) comprises four principles: mutual respect, non-coercion/non-manipulation, support of democratic values and the belief that every research act implies moral and ethical decisions that are contextual and founded on the premise the researcher builds relationships based on respect and trust, founded on a feminist ethic of collaborative, trusting and non oppressive relationships. This ethical stance presumes the researcher is committed to personal accountability and one who shares experiences emotionally; as an RN and a woman I was able to identify with and apply these principles during this ethnographic study.

Hammick (1997) suggests 'all health care practitioners have a responsibility to ensure their investigative work is done within the same moral boundaries that guide their routine work' (p.15), a process commencing at the research proposal stage. Hammick's Research Ethics Wheel [REW] provided the framework for 'ethical self scrutiny', helping with application of the principles and process of moral reasoning prior to the research being conducted, and subsequently throughout the research process.

The REW shown in Figure 42 consists of four quarters, each containing four segments; through focusing on each segment the researcher had a comprehensive tool to think through and learn more about the ethical issues surrounding the ethnographic study.

Figure 42: Research Ethics Wheel [REW] (Hammick (1997)).



The outcomes of performing ethical self scrutiny using the REW is shown in Appendix 24, points were then summarised into an applied ethical plan shown in Table 19, which was used throughout the study. The main ethical issues surrounding this ethnographic study were: gaining approval to conduct the study, informed consent and anonymity/confidentiality; how each was approached is now reported.

Table 19: Applied ethical plan.

| <i>Ethical Issue and Underpinning principles</i> | <i>Applied ethical practices.</i> |
|---|--|
| Permission | Formal access procedures University ethics committee, Acute Trust R&D, LREC DNM and Ward Nurse Managers Additional Points Negotiation of access - in the field Establish points of contact |
| Consent Respect for autonomy Non-discriminatory approach Freedom from coercion Right to refuse / withdraw Right to self determination | Nurse Manager / Nurse in charge of ward Short presentation at Senior Nurse meeting Detailed information sheet regarding the study Daily discussion prior to fieldwork in the ward Advanced notification of fieldwork (duty rota) Nurse Participants Information sheet and role of researcher. Process consenting (verbal in the field) Written consent for interviewing Patients. Verbal if asked Under specific circumstances |
| Anonymity and confidentiality Mindful of deduction | Specifically discussed in the information sheet Addressed in the consenting process. Data protection systems in place. Coding / unique identifiers |
| Privacy | Nurse - Patient relationship (withdrawal of researcher during sensitive times) |
| Non-exploitative relationships Freedom from coercion (beneficence) Co-operative, collaborative relationships Feminist standpoint | Acknowledge contributions Make self available for academic advice Don't underestimate time required for interviews |
| Risks v Benefits Freedom from harm | Need for sensitivity to RNs (managing self - disclosure) Risk of mere inconvenience observed Awareness being researched can be stressful |
| Fieldwork dilemmas | Clarify lines of communication and means of dealing with problems should they arise Maintain requisite distancing (insider / outsider) Practical issues Period of adjustment, pre fieldwork training Wear uniform and badge |
| Supervision, advice and support | Director of Studies and second supervisor |
| Endorse an ethical stance from the outset | Behave morally at all times Establish a role acceptable to RNs Ethics of Nursing are consistent with ethics of research |
| Identification and management of researcher bias (Reflexivity) | Pre study autobiography Reflective diary Member checking |

Gaining approval to conduct the study.

To gain access to the Acute Trust surgical RNs three approval processes were required. Finally as the study was in one organisational unit of the Trust, gatekeeper access was secured through two further approval processes. Through maintenance of a reflective journal the approval process was able to be retraced (Hammersley and Atkinson 1995) and is now presented.

The DOH requires all research involving care professionals to be reviewed independently to ensure ethical standards are met (DOH 2001c), a practice fulfilled by Local Research Ethics Committees (LREC) (Williams 1997; Jones and Jack 1999). LREC documents were completed and I received a letter inviting me to attend the September LREC meeting 'to defend my proposed research'. The LREC meeting was 'a nerve wracking experience'. I was kept waiting 50 minutes, brought into a room and confronted by numerous people around a table, each with a distinctive (blue bound) copy of my research protocol in front of them; there were no introductions. Scrutiny of the proposed research commenced with the statement 'this is the problem with qualitative research, there's no hypothesis'. This research experience is best explored through an extract from my journal shown in Figure 43. Although I felt the meeting had not gone well the LREC letter arrived containing minor stipulations about the patient consent document, I made the amendments and was granted permission to proceed with the study.

The Acute Trust Research and Development (R&D) Directorate was approached and a comprehensive pack was dispatched requiring completion of specific documents and submission of the research proposal. The Director reviewed draft documents prior to their final submission to the R&D Directorate, which were then presented to the Nursing Research Committee and approval granted, I was registered as a researcher within the Trust and issued with an honorary contract.

Figure 43: The LREC Experience An extract from journal 5. pp.39-42.

Reflective account: written in car immediately after attendance at meeting and prior to driving the 12 miles home.

Arrived at medical institute - it very quiet - room for meeting indicated on noticeboard in entrance - I've arrived early. Found room on first floor, just off this sort of circular / racetrack corridor, in the centre of which is the library ... I could see it was the library through the glass windows to my right (I'm walking clockwise), there's not a soul in sight, as I knew the institutes layout I find myself a chair and sat down ... concern came across me, can I remember, defend everything written in the documents submitted. Called in very late - been waiting about 90 minutes, almost falling asleep on the comfy leather sofa, listening to the rain and wind ... it's been pouring down.

'I was grilled', the chair of the committee called me in and pointed me to a chair at the head of the table ... nearest the door, there they all were sitting around a long oblong table which sits about 16 -20, all I could see were suits and my distinctly bound - blue covered research proposal in front of them. I remember thinking - no one has gone before me and no one is waiting outside, I must be the only one presenting - the chairman's opening statement was 'this is the problem with qualitative research, the lack of a research question or hypothesis' - he was directing this observation to his colleagues not to me ... so I kept quiet and they all nodded to the chair. Then I was asked ... well what is your hypothesis ?

Suddenly I realised I was in a predominantly medical (positivistic) research arena - where they are used to hypotheses and double blind clinical trials. Other questions included BIAS regarding sampling - how many nurses - ACTUALLY, what if no one responds positively to the request of consent for fieldwork. My response again was qualitative describing the positive reception I had received at the ward sisters meeting last week where I was invited to outline the study ... my words were - in all hope I will get as positive a response with the written consents as the sisters indicated.

Why did I specifically choose this directorate ? How are patients going to be involved ? - well as far as I am concerned I responded, I was not collecting data on patients specifically, I would be working as an RN with the surgical nurses ... my only concern was within pre-admission clinics for which I had devised an information sheet the nurse running the clinic would discuss with the surgical patient to see if they agreed to having an additional nurse present at the time of the assessment ... they were not happy with this answer ... I explained my rationale again, adding that the idea of an information sheet had been gleaned from my own experience of visiting the GPs who had a medical student in the consultation with them..

Why do I want to be a practicing nurse in the directorate? - because anyone who knows me - knows I would wish to be a useful nurse to the busy nurses I am working with. But what about your status with junior Nurses ? how will you cope if they asked me to do a procedure that I didn't feel competent to do? Like I would in any other nursing situation - I don't think this is what she wanted to hear.

Finally the only familiar face on the committee, and the guy sitting directly in front of me was one of the surgeons from the directorate I was proposing to conduct the research - he asked Why not include junior doctors ? to which he added, it could bias the study not including them in expanded role! I defended my study by saying, this is a celebration of the surgical nurses role ... He closed my grilling on a more positive note by stating ' I look forward to seeing you in the surgical directorate ... **Total time in meeting - 50 minutes.**

To gain entry into the surgical nurse milieu involved gaining permission from a gatekeeper, the Directorate Nurse Manager (DNM). According to Hammersley and Atkinson (1995) gatekeeper permission is usually most acute during initial negotiations and on the first day in the field. As Hammersley and Atkinson (1995) point out the researcher must

be able to judge the most effective strategy is likely to be for gaining entry ... Relationships established with gatekeepers will shape the conduct and development of research (ibid., p.64).

I approach the DNM by sending her a copy of the research protocol requesting a meeting to discuss the proposed study. At our initial meeting I was made welcome and permission was given to access 'anywhere and everywhere in the directorate', and I was included as an agenda item at the next senior surgical nurse meeting headed by the DNM. I then had to convince the Senior Surgical Nurses of the value and relevance of the study. At the senior nurse meeting, I gave out packs shown in Appendix 25, and provided a 10 minute presentation related to the documents contained in the packs. Throughout the presentation I experienced nods and smiles, one specialist nurse asked more about ethnography, apart from this there were no further questions. My closing question to the group was Do you think it will be OK for me to work in all parts of the directorate, with all of you and your staff? the overwhelming response was yes, and I felt I had completed the approval process when I was invited to stay for the remainder of the meeting. This was my first fieldwork experience, as I made copious fieldnotes on the content of the meeting and responses made by the senior surgical nurses. During my next meeting with the DNM I provided her with a copy of the LREC approval letter, and obtained data on the surgical nurses so I could send out the initial consent forms.

The ethical practicalities of researching surgical nurses.

The ethical practicalities of researching surgical nursing in the dual role of Registered Nurse and ethnographer comprised the informed consent process and ensuring anonymity and confidentiality.

Informed consent.

Informed consent is inextricably linked to respecting people and their autonomy (Hammick 1997). Hammersley and Atkinson (1995) propose consenting in ethnography as a dual role of giving enough information, and providing an opportunity for people to accept or decline to be observed or interviewed. A view shared in the DOH (2001c) research governance strategy where the researcher is

responsible for selecting appropriate means of communication to ensure potential participants are fully informed before deciding whether or not to join a study (Section 2.2.3).

Four informed consent processes were used in this study commencing with written surgical nurse consent prior to fieldwork commencing, verbal or process consenting (Roper and Shapira 2000) which took place throughout fieldwork, written consent for the ethnographic interviews and finally surgical patient consent, details of each are now presented.

Pre fieldwork written surgical nurse consent.

The pre fieldwork consenting process was not only about respecting the surgical nurses' autonomy but seen as essential for setting up a contract (Baillie 1995b) with the surgical nurses, through clarifying boundaries between my roles as researcher, senior lecturer and RN when conducting fieldwork, an approach Field (1983) suggests prevents situations arising where informants treat the researcher as consultant or colleague, and a process important to raise the profile of, and establish my 'nurse' researcher identity in the surgical milieu.

The population of surgical nurses were deemed knowledgeable on the subject of informed consent given the fact consent is a key aspect of surgical care, therefore it was important I was seen to do this with the utmost of integrity. Written surgical nurse consent was approached through developing an informed consent pack shown in Appendix 26, comprising a letter and an information

leaflet providing details on the theoretical basis of the study, the role of the fieldworker, and how they might be involved in the study, a written consent form and a copy of the ethical plan. The pack was completed with a stamped addressed envelope. Through providing an informed consent pack, each surgical nurse could make a knowledgeable decision about participation in the research (Roper and Shapira 2000). The consent packs were distributed in two phases, the first 18 were distributed to ward nurse managers and specialist nurses. All senior surgical nurses returned the consent form agreeing to their individual participation in the study. I then verbally clarified with the senior nurses that I could conduct fieldwork in the surgical area they were responsible for, all agreed I could work with them individually and have access to their clinical areas.

Consent packs were then distributed to the remaining 121 surgical nurses. After two weeks only one third of the consent forms had been returned so I visited the Directorate to investigate the reason for this. On talking to several surgical nurses they were aware of the study and had received the pack, but they had not seen it as essential to complete the consent form. This situation was discussed with the ward nurse managers, and I consulted the literature on written consent in ethnography, where I became aware of the unique dilemmas of consenting in ethnography, as ethnography evolves over time (Hammersley and Atkinson 1995); to overcome this I adopted 'process consenting' (Roper and Shapira 2000, p.121).

In the field verbal surgical nurse consent.

Process consenting was employed throughout fieldwork. Prior to a fieldwork session arrangements were made to work with a surgical nurse. At the beginning of a period of fieldwork I checked with the surgical nurse if they still agreed to my working with them, and clarified my role for the shift. Throughout fieldwork I was acutely aware verbal consent provided at one stage of the study could not

be assumed at another, thus process consenting was an ongoing feature of fieldwork.

Key informant written consent for ethnographic interviews.

Written consent was secured for all ethnographic interviews. The potential interviewee was approached in the ward or department and the possibility of conducting a formal interview with them was discussed, I then provided an interview consent pack comprising a letter and an interview consent form shown in Appendix 27. After the RN had had time to read the documents he/she was approached to discuss his/her decision regarding the proposed interview. If the nurse agreed to being interviewed, a time and place was arranged. On commencing each ethnographic interview, the tape recorder was turned on and the content of the consent form was discussed with the surgical nurse, where I emphasised the anonymity and confidentiality aspects of the transcribing and reporting stages of the study. Two identical consent forms were signed, one copy was given to the surgical nurse and one was retained.

Surgical Patient Consent.

Baillie (1995b) notes that in many prominent ethnographic nursing studies where research involved the gathering of data on practising nurses engaged in direct patient care, authors omitted to show how patient consent was addressed. As little guidance was available on this aspect of nursing research the researcher, as an RN undertaking fieldwork with another RN, adhered to her code of professional conduct regarding patient consent. When a patient or relative asked specifically about my role I honestly acknowledged I was 'a nurse lecturer conducting a study of how surgical nurses roles were developing' which was received with interest by many patients.

Where the researcher observed surgical nurses working in areas outside the ward, for example conducting a pre-admission clinic, a patient consent document

was used, shown in Appendix 28. The surgical nurse asked the patient if I could be present during the assessment, the reason for my presence was explained and the patient was left with a copy of the consent form, providing the patient with an opportunity to decline my being present during their care episode. Throughout fieldwork there were sensitive clinical scenarios where it was inappropriate for an additional member of staff to be present, for example where a Senior Nurse was explaining to relatives the terminal effects of their relative's condition, under these circumstances I made myself scarce.

Anonymity, confidentiality and security of data.

All handwritten fieldnotes were entered into a spiral bound notebook, thus avoiding the use of single sheets which could easily be misplaced in a busy clinical environment. Fieldnotes were word processed and any identifying features relating to the ward, clinical service or surgical nurse were anonymised via a coding system. Tape recorded interviews were transcribed and any identifying features were again anonymised. All word processed data was stored on a password protected computer in the ethnographer's home, no data has been electronically transmitted, and one back-up copy has been maintained on a portable hard drive. The original spiral notebooks, the interview tapes and the backup portable hard drive are all securely stored in a locked filing cabinet in the author's home.

Establishing trustworthiness in this ethnographic study.

Guba and Lincoln's (1981) work on rigor sets the scene for much discussion in nursing as to what criteria should be followed to ensure trustworthy qualitative research. Guba and Lincoln (1981) developed what have become known as a set of parallel terms to better fit the assumptions of the naturalistic paradigm and to be used instead of the dominant positivist language of the time (Koch and Harrington 1998, p.884). These terms are credibility (for truth value), fittingness (for applicability), auditability (for consistency) and confirmability

(for neutrality). Lincoln (1995) acknowledges that at the time of publishing the parallel criteria she was unaware of the integral relationship between standards for quality and standards for ethics in inquiry, resulting in her proposal that research on this is a dialogue about emerging criteria, suggesting qualitative research should embrace a set of three new commitments outlined in Figure 44 proposing these criteria are 'relational' where there is a need to validate relationships between inquirer and those who participate in the inquiry.

Figure 44: Emerging criteria (Lincoln 1995, p.277).

- To new and emergent relations with respondents.
- To a set of stances: professional, personal and political, toward the uses of inquiry and toward its ability to foster action.
- To a vision of research that enables and promotes social justice, community, diversity, civic discourse and caring.

Hall and Stevens (1991) add to this debate through setting forth a feminist perspective on criteria on which to judge the authenticity of qualitative research, which includes the issues of voice and reciprocity, a feminist influence which led Lincoln (1995) to draw attention to the fact texts which claim whole and complete truth, or present universal, grand and generalizable knowledge, are unauthentic and misleading. Lincoln (1995) proposes a text which displays honesty and authenticity and 'comes clean' about its own stance and the position of the author demonstrates greater rigor, whereas detachment and author subjectivity are barriers to quality, not insurance of having achieved it. Koch and Harrington (1998) refer to these new criteria as an 'expanded conception of rigor' (p.886), acknowledging the inclusion of moral and political contexts which go beyond a set of methods for gathering and treating data to a more rigorous approach to the entire process.

There appears to be a general consensus that no single, overarching set of quality criteria can be applicable to all forms of qualitative research. Lincoln (1995) steers the naturalistic enquirer to the idea that specific criteria might

apply to specific kinds of research. Having explored the theoretical base of quality criteria in relation to qualitative and ethnographic research, this ethnographer saw benefits in synthesizing a set of practices which do not conveniently fit into one author's proposals for quality criteria when conducting this ethnographic study. A range of techniques was utilised, described as an 'eclectic' approach to establishing trustworthiness in this study, the aim being the conduct and reporting of a 'good', 'trusty' qualitative study, one on which 'others' can judge its trustworthiness for themselves. The set of techniques used to address trustworthiness in this study were: acknowledging personal investment in the study, respondent validation / member checking, prolonged engagement and persistent observation and finally debriefing and feedback, each is now explored.

Acknowledging personal investment in the research.

Denzin and Lincoln (1994) remind us 'behind all the phases of the qualitative research process stands the biographically situated researcher' (p.12), a quote reminding this ethnographer she was the 'other', the human instrument in this ethnographic research. This positioning of the qualitative researcher has been a source of criticism, with some suggesting qualitative research is biased, distorted and even subjective (Berg and Smith 1988). Techniques have been proposed which aim to establish researcher 'neutrality', namely 'bracketing', a process of suspending beliefs (Schwandt 2001) which for me appeared unrealistic as I felt it was more helpful to think in terms of increased self awareness and developing a non judgmental orientation in this ethnographic study.

Bias according to Wolcott (1995) is something the ethnographer must live with, referring us to the concepts of good and bad bias, where good bias gets the job done by lending focus to the research, and bad bias is a matter of excess which can unduly affect the research. Wolcott (1995) suggests ethnographers harness

their biases, through identifying perspectives brought to their studies from which one can anticipate how they may affect what we report...

covet your biases, display them openly and ponder how they help you formulate both the purpose of your study and how to inquire (p.165).

LeCompte (1987), in referring to ethnographic research and the criticism it is biased and subjective, reiterates the need to identify sources of bias and subjectivity in the researcher's own make-up as a critical feature of the work she/he does, suggesting ethnographers are held to the highest form of disciplined honesty, but acknowledge the lack of guidelines for identifying biases in the ethnographic instrument. Therefore she proposed the need for 'an ethnography of mind' , a process for determining conscious and unconscious sources of bias she found useful in her own work and originating from her own personal experience and professional training. Fetterman (1998) further describes a fatal error in ethnography as 'ethnocentric behaviour' which he describes as

the imposition of one culture's values and standards on another, with the assumption one is superior to the other (p.23).

These assumptions steer us to the idea of a 'quality ethnographer' being one who can suspend personal valuation of any given cultural practice, preventing the ethnographer from making inappropriate and unnecessary value judgements about what they observe (Fetterman 1998), achieved by making explicit biases and by trying to view others' cultural practices impartially, a process he describes as a 'non-judgmental orientation' (p.23).

To aid identification of the ethnographer's personal investment in the research, sometimes described as biases, subjectivities, prejudices or ethnocentric behaviour, three techniques were used to achieve what Berg and Smith (1988) described as self scrutiny, a process of 'keep a check on myself' as the human instrument and deemed an essential aspect of being an integritous researcher.

Construction of a pre-fieldwork biography.

An autobiography was created a decade ago as part of my masters degree, recently this was reviewed alongside the development of my nursing profile, required for re-registration purposes. Looking back on these documents at the beginning of this study they comprised descriptive accounts with many gaps, nevertheless they provided a starting point. I expanded my biography to include contextual and motivational data, resulting in the construction of a detailed autobiography on which the ethnographer could reflect.

I shared details of the biography with my research supervisor, herself a writer on reflective practice (Glaze 1998; 2001; 2002) who suggested 'what you need to identify is what you bring to this study, your expertise'. One day I asked myself 'why am I studying what I am studying, and what do I bring to this study?' this was the turning point in my reflective analysis, together with LeCompte's (1987) proposal for reviewing one's autobiography from two sources of bias; personal experience and professional training. The outcomes of this reflective appraisal of my biography has been: an uncovering of where my professional interests and experiences originate from related to surgical nursing and role expansion; an appreciation of the value of critical reflection to uncover assumptions and biases brought to this study; and greater self awareness and understanding of my motives, attitudes and values, what Roper and Shapiro (2000) describe as the ethnographer's 'honest acknowledgement of personal baggage' (p.114), outlined in the introduction to this thesis.

Maintenance of a research journal.

In the context of research Guba and Lincoln (1985) view the reflective journal as providing information about the human instrument, and propose the content includes a daily schedule and logistics of the study, a personal diary and a methodological log, which provided an opportunity for catharsis, reflection on actions, values, interests, speculation and methodological decisions. Sandelowski

(1986) proposes the researcher view him/herself as a subject in his/her own study, and through maintaining a journal of fieldworker experiences can lead to the offsetting of 'going native' by deliberately focusing on how the researcher influenced and was influenced by a subject. Credibility of a study is seen to be enhanced where a researcher describes and interprets his/her behaviour and experiences as a researcher in relation to the behaviour and experience of subjects (Sandelowski 1986; Koch 1994). Koch (1994) also refers to the maintenance of a fieldwork journal as a means of increasing researcher self awareness, and the credibility of a study (p.977).

Each diary was an A4 fixed page book, which contained handwritten entries, pasted-in mind maps and copies of letters and correspondence, all of which have at particular points in the study contributed to focusing my thinking on aspects of the research process. The journal has facilitated critical dialogue with self on fieldwork experiences through periodic reflective activities where journals were read and re-read; this led to recognition of work achieved, work in progress and the challenging of assumptions and interpretations. I have increasingly come to realize the recording of 'everything', whilst time-consuming, provides a detailed document which prevents forgetting and a realisation that the PhD journey is a complex and often convoluted one. Good ideas on one specific day can soon be forgotten if not committed to paper in an organised and logical fashion.

The overall outcome of constructing the biography and maintaining a journal has been to facilitate an increased sense of self awareness and hopefully attention to the potential for being overly judgmental, as Fetterman (1998) points out the ethnographer should strive for a non-judgmental orientation (p.23). Additionally the documented accounts lay a decision trail (Koch 1994) for others to judge progress in the study and to aid construction of a reflective evaluation of the study process and product included in the final chapter.

Utilization of 'Member Checking' processes.

Fieldwork was the approach to data collection in this ethnography, a technique employed to grasp the EMIC perspective (Roper and Shapira 2000), and to discern the often hidden, tacit knowledge of surgical nurses, revealing cultural practices, attitudes and values. Data collection and analysis during fieldwork was an iterative process (Holloway and Wheeler 1996), whereby the ethnographer, whilst working with and learning from the surgical RNs was in a position to utilise techniques purported to promote credibility (Baillie 1995a) and trustworthiness, through verifying the meaning of data from sources from which it was gathered; a process described by Guba and Lincoln (1981) as 'the backbone of satisfying the truth criteria' (p.110). Different authors propose member checking procedures be applied at different points in the research process, some of which are shown in Figure 45.

Figure 45: Member checking at different stages of the research process.

- Continuously in the field as data is gathered, both formally and informally (Lincoln and Guba 1985).
- Returning transcripts with data analysis (Field 1983).
- Returning to respondents individually and collectively with tentative analytic codes and categories (Lincoln and Guba 1985).
- Restating ideas and instances to those who shared their ideas (Leininger 1994).

Although member checking processes have been described as a means to producing trustworthy data (Field 1983, p. 143) and achieving credibility of data (Hall and Stevens 1991), they are not without criticism and cautions. Koch and Harrington (1998) point out there are more problems with this technique than the literature reveals and provide an account of two issues the researcher might face in following the member checking procedure. Firstly, the fact that it may be difficult to trace participants, and secondly the fact that when data is analysed and themes are generated it is difficult for individual participants to identify their specific contribution. In guarding against this Morse (1998) proposes factual and interpretative content should not be verified at the end of

a study but verified step by step, piece by piece during the research process. In view of these dilemmas in member checking procedures two member checking procedures became integral to the ethnographer's role.

Individual member checking.

In the role of participant observer opportunities were available to clarify with surgical nurses the meaning of their actions and my understanding of what they were saying, through the question and answer technique. Following transcription and tagging of the fieldnotes their content was discussed with the RN I had been working with at the earliest possible opportunity, usually the next shift. The tagged interviews were returned to the surgical nurse for authentication, after a short period I arranged to meet each interviewee to answer any questions and clarify any points I was unsure of, and to rectify any misinterpretations on my behalf. In many instances returning interview transcripts and discussing them with the surgical nurse led to further insights being revealed as the surgical nurses themselves had undergone a period to reflect on their interview transcripts, providing me with additional ethnographic data.

Group member checking.

The Senior Nurses' monthly meeting became a forum where I was invited to give an update on progress related to the study. I used 'my slot' to provide a brief overview of my initial interpretations of surgical nursing practice and role expansion which proved useful, as Senior Nurses conveyed multiple perspectives on these evolving themes which often led me to seek out additional data on particular topics and to revise hypotheses on an ongoing basis.

Prolonged engagement and persistent observation.

Prolonged engagement and persistent observation are inextricably linked and typically ethnographic, originating in anthropological studies of distant and sometimes exotic cultures. Prolonged engagement was achieved through

spending sufficient time in the field to learn the culture (Lincoln and Guba 1985) and is a practice Leininger (1994) sees as improving the believability of findings through the ethnographic process of cumulative knowing. Kirk and Miller (1986) suggest prolonged periods in the research community enhance researcher sensitivity to discrepancies between the meanings presumed by the researcher and those understood by the target population. Prolonged time in the field combined with persistent observation facilitated my achieving data saturation and immersion. Leininger (1994) sees saturation as the full taking in of occurrences, to know it as comprehensively and thoroughly as possible, where no further explanation and interpretation can be found, and achieved through searching for conflicting evidence and the use of negative case analysis which enhances the credibility of the findings, through reworking hypotheses as more information became available, a process Lincoln and Guba (1985) suggest lead to the revising of hypotheses with hindsight, and the sorting out of irrelevancies which lead to the detection and rectifying of distortions.

An additional feature of my prolonged engagement and persistent observation is that it allowed for the development and building up of trust with participants (Guba and Lincoln 1989). Trust with those studied is a topic that has become increasingly important in qualitative research and health care (Goold 2002), a philosophy originating in feminist research. Hall and Stevens (1991) refer to the qualitative researcher's role as 'relational' (p.26), where rapport, honesty, mutuality and reciprocity and criteria of rigor are to be aspired to. This ethnographer conducted the study in the participant observer role using professional nursing qualifications and 25 years of surgical experience to work with those studies; for me this professional background and philosophy facilitated a building of trust with the surgical nurses.

A further opportunity provided by prolonged engagement and persistent observation and an important feature of ethnography in terms of credibility was context preservation (Germain 1993). Here the researcher role aimed to ensure

preservation and conveyance of 'meaning in context' (Leininger 1994, p.106). Through context preservation and presentation of the contextual aspects of the ethnographic findings, others can judge the fittingness of the ethnography to their own context as ethnographic researchers agree generalizability is an inappropriate and impossible aspiration, a legacy left over from the positivist paradigm. Wolcott (1995) states categorically 'you don't generalise from one study as the case remains particular'. Fittingness (Guba and Lincoln 1989; Lincoln and Guba 1995; Koch 1994), transferability (Leininger 1994) and perspicacity (Stewart 1998) are all terms that imply qualitative research has value in other contexts. In order for that 'fit' or 'transference' to be made in relation to the study reported here, 'the original context' in which the data was generated and analysed is hopefully adequately described so that a judgement of transferability can be made by readers (Koch 1994).

In order to provide readers with an opportunity to judge the degree of fittingness between the context in which this study was undertaken and their own clinical environment, this report contains much contextual detail achieved through 'thick description' (Holloway and Wheeler 2001) and the use of unaltered narrative accounts be included in research reports, as a means to assuring the consistent and truthful presentation of field data (Slevin and Sines 1999). In this study I have used thick description in Part III of the thesis before interpreting the findings in Part IV, the latter being open to re-interpretation based on a reader's theoretical position, whereas for the former I recommend going out into the field and spending time validating them as I did to develop an understanding of current nursing practice.

Debriefing and feedback.

For the researcher, an opportunity to gain feedback on thoughts, ideas, and experiences is a welcomed activity and was achieved through formal and informal feedback and debriefing opportunities in this study. Formal feedback was obtained through the research supervision process in the university where the

study was undertaken. This was seen as an external check on the inquiry process (Lincoln and Guba 1985) and an aid to establishing credibility. Both supervisors offered in their own way important insights into my practical research activities, assumptions and more recently written accounts. Each meeting stimulated consideration and exploration of additional perspectives (Long and Johnson 2000), an opportunity to formally identify progress, which spurred me on to another phase of the study. Informal feedback was obtained through peer debriefing (Robson 1993) where I explored ideas with other nurse lecturers, encouraging them to challenge my ideas with the consequent requirement to defend them critically, and as the study progressed I took the opportunity to present seminars within research forums throughout the university and regionally.

Conclusion Part II.

This chapter has laid bare the research process. In (re) presenting accounts from surgical nurses and from the ethnographic fieldnotes, data has not been edited or 'tidied up' in any way, the RNs' words are presented as they were spoken, any parts of a quote which have been edited are because they are not directly relevant to the discussion as indicated by (...). This approach to presenting data allows the researcher to remain as true to the data as possible, by providing a 'vicarious experience' for the reader (Sandelowski 1994). Other academic conventions utilized to ensure faithfulness to the data are shown on page 9.

Part III: The ethnographic findings.

Having set the scene in Part I for Nursing developments in the General Hospital since passing of the 1919 Nurses Act, and having laid bare the research process in Part II, I now turn to presenting the ethnographic findings.

Chapter four: The city, its hospital and its surgical services, introduces the social world of the Registered [surgical], Nurse, locating him/her within the Acute Trust hospital from a strategic to an operational (clinical directorate) level where the surgical nurse labour force manned the surgical wards 24 hours a day, seven days a week and 52 weeks a year.

Chapter five: The Surgical Nurse labour force, labour process and conditions of labour production, in essence is about the day to day role of the different grades of RN within the surgical directorate. The RNs provide a vivid account of their struggle to maintain adequate staffing levels and the issues they consider to be a constant battle, that of their working conditions.

Chapter Six: Surgical Nurse role development, role expansion and role extension turns to addressing six dimensions of the surgical nurse role found to be in operation within the surgical milieu, one was totally unanticipated which in the words of an experienced ward sister **just like a role can expand so can it go backwards (fieldnotes).*

Chapter 4: Rodingham, The Rodin and the provision of surgical services.

Rodingham is a once industrial city in middle England, described in the annual public health report as 'a new city, a city with a long and proud heritage', one of the most densely populated places in the country with approximately 9,000 residents per square mile, residents who experience high levels of unemployment, and life expectancy in the lowest 15% (Census 2001), with ethnic minority groups accounting for approximately 18% of the population. Rodingham ranks in the top 30 of the 99 most socially deprived districts in England, and is the third most deprived area in the region, as a result of which it was designated a Health Action Zone (HAZ)⁷³ in 1998. Death rates from heart disease and stroke remain significantly higher than the national average, as do smoking related and cancer deaths, with the percentage of General Practitioner (GP) recorded diabetics significantly higher than the national average. The rate of violent crime in the city is high, with 5,400 incidents reported in a single year.

On creation of the NHS a voluntary and a local authority hospital served the City; since the 1950's a 'Not for Profit, Independent Hospital has also been in existence. A capital development programme in the early 90's culminated in the two NHS hospitals being centralised onto one site with closure of the older hospital. NHS reforms brought about in the White Paper 'working for patients' (DOH 1989) resulted in The Rodin becoming a third wave Acute Trust in April 1994.

The Rodin provides acute NHS hospital services for 400,000 residents, described in the government watchdog report as better than the English

⁷³ **Health Action Zone (HAZ)** is a partnership between the NHS, local authorities, the voluntary and private sectors and local communities, launched by the government in 1997 to find new ways of tackling health inequalities in some of the most deprived areas in England.

average in all clinical indicators. Rodin houses 851 in-patient beds, with the Trust executive projecting a rise in the number of beds as a result of the Trust's ambitious expansion programme. Over the preceding two years 240 new jobs were created, making Rodin the second largest employer in the city, with 3,780 whole time equivalent (WTE) employees, projected to rise to approximately 5,000. Reflected in documents throughout Rodin are the Trust's mission statement:

Our purpose remains to provide the highest quality of patient treatment and care possible from the resources in the Trust.

supplemented with four key aims:

- To provide excellent clinical services for patients,
- To become a leading national training provider,
- To strengthen our research base,
- To become an excellent organisation.

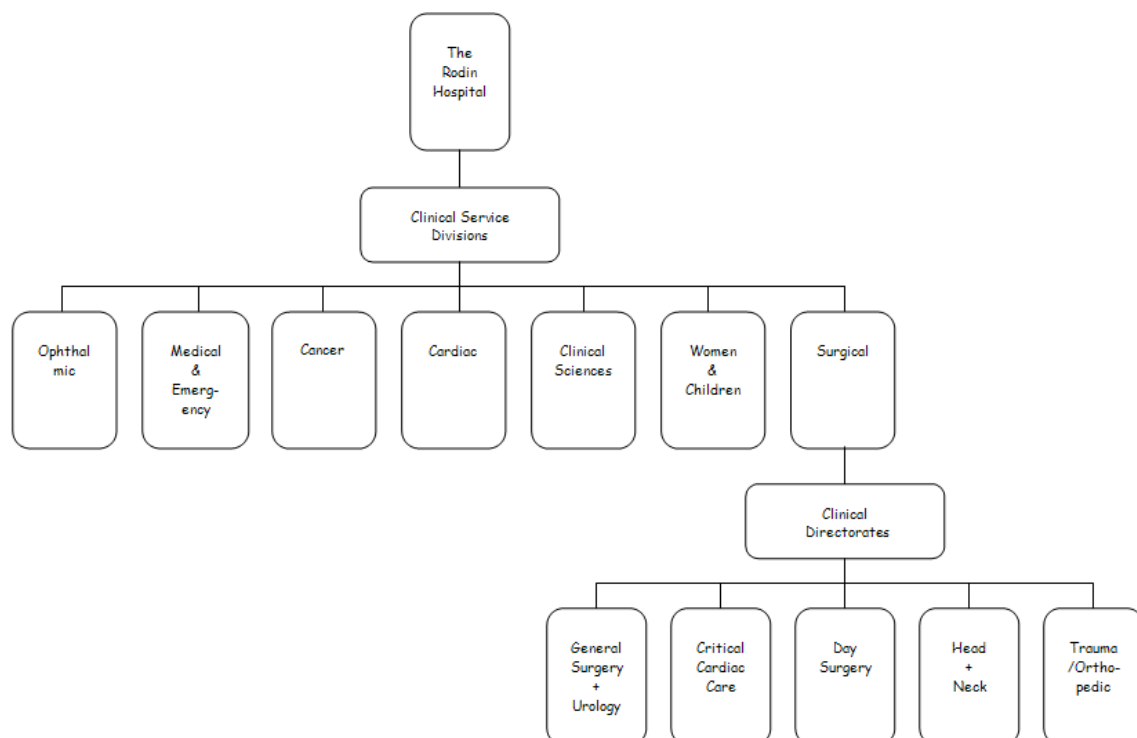
In addition to the ambitious expansion in clinical services, the Trust declared its intention to gain teaching hospital status for medical education.

Rodin is undoubtedly an organization with ambition, evidence of which is experienced on entering the one way traffic system, where you pass numerous new builds, heavy plant machinery and a prolific number of contractors as the Trust gives birth to a New Labour modernization centre, a purpose built cardiac unit. Evidence of expansion is also seen inside the hospital walls as critical care services undergo refurbishment, including a state of the art £50,000 patient hoist. An estimated 70 million pound investment programme was under way during the three year period when fieldwork was conducted. The government watchdog review praised Rodin for improvements to patient waiting times, and two services were identified as exemplars of good health service practice: the first being obtaining feedback from breast care and fractured neck of femur patients; the second was for the Trust's introduction of a Fast Track referral system for suspected cancer patients. These two positive acknowledgements

were overshadowed by concern in relation to risk management, public involvement and staff training⁷⁴.

Overall management of the Acute Trust is via a senior management directorate, headed by the Chief Executive. Operationally Rodin is divided into seven clinical service divisions, each headed by a General Manager, below which are a Head Nurse and Business Manager; each clinical division is sub-divided into clinical directorates shown in Figure 46. This study focuses on the General Surgery and Urology clinical directorate.

Figure 46: Organisational chart (from fieldnotes).

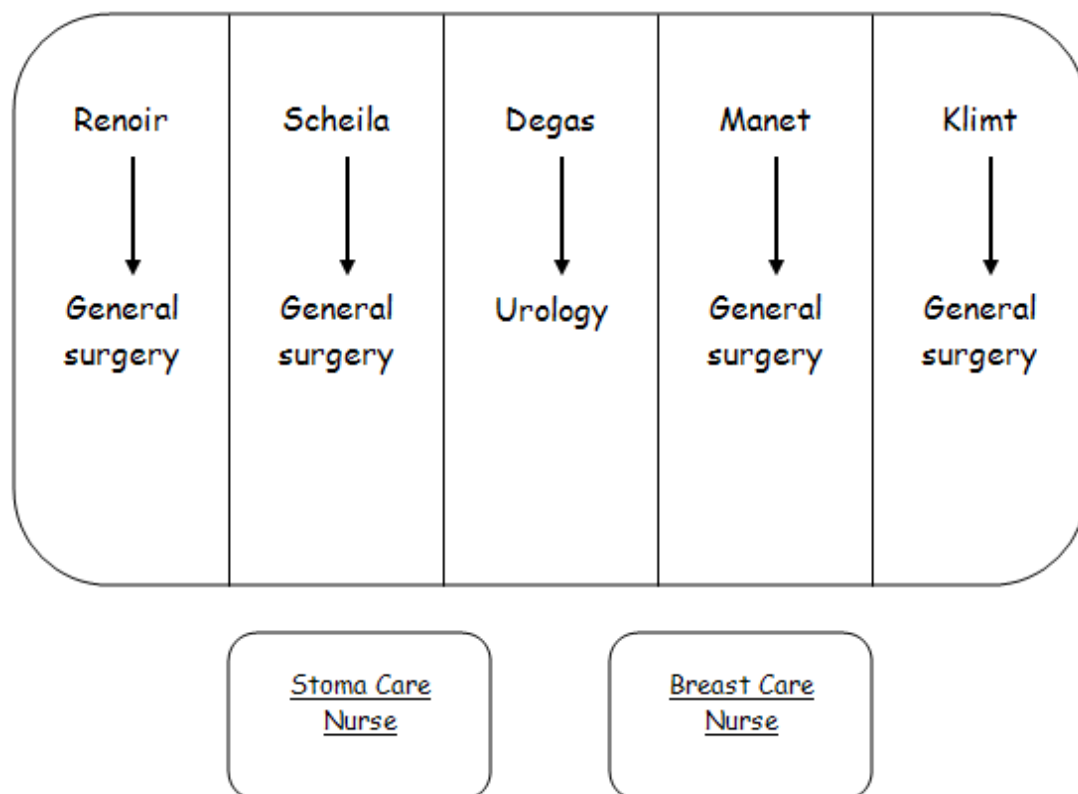


⁷⁴ Risk management across the Trust was described as 'lacking a strategic approach', because individual responsibilities and Trust-wide systems for assessing and reporting risks were unclearly managed. Also 'patients' views were gathered ad hoc' and 'complaints were not fully followed through'. Regarding staff views they were criticized as 'having an un-systematic approach which lacked co-ordination', with management not sharing information with staff, staff training needs had not been identified, the system for induction and appraisal of staff varied across the Trust, resulting in some staff being unclear about their roles and responsibilities.

A decade of developments in Rodin's General Surgery and Urology Directorate.

On becoming an Acute Trust (1994) the Clinical Directorate structure came into being; for General Surgery and Urology the Directorate comprised four General Surgery wards, one Urology ward and two Specialist Nurse services (for Breast and Stoma care), depicted in Figure 47.

Figure 47: **The General Surgery and Urology Directorate**
(from fieldnotes).



Senior Surgical Nurses consistently and persistently made reference to factors influencing the evolution of surgical services over the last decade and thus their provision today; the recollections and documents given to me by Senior Nurses, supplemented with a search of the hospital's archives, revealed two approaches that were taken to develop surgical services during the decade preceding this study. First were nursing labor process changes brought about following the appointment of a Directorate Nurse Manager (DNM) who headed up the clinically based RNs in the new Directorate structure. Second were strategic

changes to surgical service provision brought about by the non-clinically based nursing and Trust managers.

Nursing developments.

The newly appointed DNM is described by a Ward Manager as having **a monumental effect on the organisation of nursing and what us Surgical Nurses do (fieldnotes)*, with another Ward Manager commenting **wouldn't believe what we have to put up with now, she [the new DNM] wouldn't have allowed it (fieldnotes)*. The DNM's legacy is her replacement of the Team Nursing labour process with Primary Nursing which she was able to achieve with the Project 2000 replacement monies through negotiating a revised nursing establishment with Trust managers⁷⁵ resulting in each in-patient surgical ward having one Ward Manager (Senior Sister), four Primary Nurses (Junior Sisters), eight Associate Nurses (Senior Staff Nurses) and a variable number of Junior RNs. The revised Nurse staffing resulted in four Primary Nursing Teams for each 28 bed surgical ward. This created a ratio of seven acutely ill surgical patients being cared for by a Primary Nursing team, who provided continuity of care on a 24 hour, seven day a week basis, and implemented at a time when the government launched the Patients' Charter 'Named Nurse' (DOH 1991), and the previous Strategy for Nursing (DOH 1989) both endorsing Primary Nursing on the grounds this nursing labour process led to high quality patient care.

Alongside implementing Primary Nursing, the DNM re-advertised all Senior Surgical Nurse posts, only appointing existing Senior Nurses into Primary and Associate Nurse posts if they agreed to undertake a nursing diploma or degree.

⁷⁵ **Nursing Establishment:** The existing establishment of permanent Nursing staff comprising one Ward Sister, possibly two Junior Sisters, one or two Senior Staff Nurses, two or three Staff Nurses, and one or two part time Nursing Auxiliaries. In addition to permanent nursing staff were a variable number of student nurses. Introducing Primary Nursing resulted in the Senior Ward Sister becoming the Ward Nurse Manager, the Junior Ward Sisters became the Primary Nurses and the number of these was increased to four per ward, their role being to head up a Primary Nursing team. To complete the Primary Nursing Team existing senior staff nurses became Associate Nurses.

Those appointed as Ward Managers were enrolled into the Trust commissioned MBA or NVQ Level 4 management programmes. These educational edicts were occurring when the on-site School of Nursing became a pilot site for the ENB Higher Award; subsequently Senior RNs who already held a Diploma in Nursing (DPSN) entered the BN Hons Higher Award, and those not meeting the entry criteria⁷⁶ either undertook the Diploma in Nursing (DPSN) or entered the new ENB A25 Surgical Nursing course. This human capital expansion strategy resulted in large numbers of RNs completing Diplomas and Degrees, three Senior RNs provided me with their professional profiles shown in Table 20.

Table 20: Senior Nurse Professional Profiles.

| Nurse Title | Initial Qualification | Professional Qualifications |
|--|--|--|
| Primary Nurse | RN Dip HE | <ul style="list-style-type: none"> • ENB A25 Surgical Nursing • DipHE Acute Care • BSc(Hons) Health Sciences |
| Primary Nurse / Night Nurse Practitioner | Enrolled Nurse (SEN) State Registered Nurse (SRN) | <ul style="list-style-type: none"> • GNC Art of Examining • ENB 931 Care of the Dying • ENB 928 Developing Nursing Care • ENB 998 Teaching and Assessing • Dip HE Acute Care • C&G 730 • BSc Clinical Practice • Care of the Severely Compromised • ALS • Tissue Viability |
| Ward Manager | RGN | <ul style="list-style-type: none"> • ENB Stoma Care • ENB 998 Teaching and Assessing • ENB TPN management • Extended Role IV Drug Administration • Research Appreciation • ENB A25 Surgical Nursing • DPSN • BSc Hons Health Studies. |

⁷⁶ which was full Diploma Status and a minimum five years' clinical experience in a specialist nursing field.

To develop the infrastructure for Primary Nursing Senior Nurses created a Nursing Philosophy and a set of objectives shown in Figure 48, which are displayed on ward notice boards today, and a booklet was developed for surgical patients on Primary Care, transcribed in Figure 49, all of which indicate RNs were fully operationalizing the government's Named Nurse through Primary Nursing, informing patients they could expect holistic, 'continuity based' care.

All paper documents underpinning the new Primary Nursing labour process were radically overhauled, with the RNs adopting Henderson's Model of Nursing to apply the nursing labour process, all of which underpinned the philosophy of individualized, nurse led care, delivered by experienced RNs who in the process supported Student Nurses and new RNs to become part of the Primary Nursing team.

Henderson's Model was operationalized to the day-to-day care of surgical patients through creating core care plans for common surgical patient needs ie pain, nausea and vomiting and fluid deficit, by individual RNs seconded to the diploma and degree programmes using the Higher Award philosophy of integrating theory and clinical practice. Topics for the RNs' assignments were negotiated via a tripartite system [student, DNM and academic] with the outcome influencing the development of nursing care for the benefit of staff and surgical patients by incorporating research finding into core plans of care⁷⁷. A Primary Nurse provided me with her BN research project which investigated 'early discharge for women undergoing breast surgery', presenting the research findings to consultants and managers leading to the development of a protocol containing eligibility criteria for care at home with a wound drain, freeing beds for further admissions, and meeting women's needs to return home as soon as clinically possible.

⁷⁷ For example one nurse conducted a review of the literature on the use of anti-emboli stockings to prevent surgery related deep vein thrombosis (DVT) and as a result used the findings to construct a care plan for use throughout the surgical directorate.

Figure 48: Surgical Unit Ward Philosophy and Ward Objectives (fieldwork document).

Surgical Unit.
Ward Philosophy.

We believe that every patient should be treated and cared for in an efficient and courteous manner, respecting their needs and wishes and that the quality of their stay in this ward is of paramount importance. Based on this, we are committed to an holistic, research based approach to nursing care. It is our belief that each individual has the right to receive a high standard of care, planned by a highly qualified nurse, supported by the patient and their family / carer.

All available facilities will be utilized in order to aid recovery or rehabilitation of our patients.

In order to provide and maintain high standards of care, it is essential to have accurate and consistent communication within the multidisciplinary team.

It is our aim to provide an environment conducive to the needs and well being of both permanent staff and students. We value the contribution that each member of staff provides and we will endeavour to assist each member to reach their full potential.

Surgical Unit.
Ward Objectives.

Aims:

To provide a channel of education for patients, carers and nursing staff.
To develop high standards of nursing care

Objectives:

To have regular meetings so that staff will be encouraged to participate in the development of nursing practice.
To continue to develop the philosophy of Primary Nursing.
To provide health education/promotion for all patients and staff.
To develop communication skills amongst all disciplines of staff.
To liaise with the university to assist in the development of teaching programmes for students and all qualified staff.
To encourage self development, theoretically and practically for all grades of staff.
To continue to develop and upgrade core care plans.
To endeavour to promote research based nursing practice.

(Fieldwork documents DDD).

Figure 49: Information booklet for patients on Primary Nursing in the General Surgery and Urology Directorate (fieldwork document).

Primary Nursing

Welcome to

We hope that your stay with us will be as comfortable as possible. We practice Primary Nursing on this ward, that means that throughout your stay you will have a named nurse who will be responsible for your care. She will be assisted by a team of associate nurses who will care for you in her absence.

You can expect your primary nurse to:

Get to know your family
Plan your care with your doctor
Plan with you the nursing care, to meet your needs.
Explain your needs to the associate nurse, who will care for you when your primary nurse is off duty.
Tell you what to expect before all tests or treatment.
Teach you about health care related to your condition.
Find all the answers to your questions, about your hospital stay.

We need you to:

Tell your Primary Nurse what you need.
Keep the nurse informed about how you feel and the things that are on your mind.
Let your nurse know how you feel about the care you receive.
Tell your nurse if you have an idea or preference about your nursing care.

We want you to be involved in any decisions concerning your nursing so please feel free to ask any questions, your nurse will be happy to answer them.

Below is a list of all involved in your care:

| | |
|---------------------------|-------|
| Your Primary Nurse | ..... |
| Your Associate Nurses | ..... |
| | |
| Your Consultant | ..... |
| Your Senior Registrar | ..... |
| Your Senior House Officer | ..... |
| Your House Officer | ..... |

A further Nursing development was the evolution of Specialist Surgical Nurse services. Initially in this Trust there were only two Specialist Surgical Nurses, the Stoma Care Nurse and a Breast Care Nurse; the DNM saw the importance of extended and expanded nursing roles through endorsing two classifications of Specialist Nurse, the Clinical Nurse Specialists (CNSs) educated to degree level and the new Advanced Nurse Practitioners (ANPs) who were seconded to the regional masters programmes⁷⁸. The Specialist Nurses evolved to provide services to diagnostic related groups (DRG), and comprised Upper Gastro Intestinal, Lower Gastro Intestinal, Urology, Breast care and Vascular. The Upper GI and Lower GI nursing services developed from the original and most long standing stoma care specialist nurse.

Strategic developments.

The 90's also saw major changes to the provision of surgical services within the Trust through their responses to the government drive to increase day surgery by building an on site, self contained day surgery unit, which meant no admissions to the general wards of day surgery patients. A slow and often unnoticed aspect of surgical service provision in Rodin is ward specialisation, the precedent having been set in the 60's and 70's where dedicated orthopaedic and ENT wards evolved, closely followed by urology wards in the late 70's to early 80's. Increasingly during the 90's the trend in Rodin has been to employ General Surgeons with a defined specialism, most notably vascular, upper GI, Lower GI and Breast, a trend which has increasingly become reflected in the surgical directorate of Rodin. With vascular surgery advances for emergency and elective Abdominal Aortic Aneurysm (AAA) repair and the more recent vascular procedure carotid end arterectomy, the Trust responded by converting a six bed bay in the vascular ward into a four bed High dependency vascular Unit.

⁷⁸ Although the DNM adopted the ethos CNS role was at degree level and ANP role was at Masters level, this was at the time an unregulated requirement.

Two further innovations in the Directorate's surgical provision were first the setting up of a new ward for Short Stay Surgical Patients, open Monday to Friday, re-housing patients previously admitted to the major in patient surgical wards, and second in response to the increasing government pressures to reduce waiting times in Accident and Emergency (A&E) a Surgical Ward was reconfigured into a dedicated Surgical Assessment Unit (SAU) which accepts emergency surgical referrals as opposed to being dealt with in A&E.

The hospital appointed a Care pathway co-ordinator **to drive through Rodin protocol based care (fieldnotes)*, her remit in the surgical division was initially in the Orthopaedic Directorate, but she recently moved into General Surgery working on pathways for cholecystectomy and hernia. I first met the co-ordinator at a meeting on the urology ward who were developing the prostatectomy pathway to support the 'hospital to home scheme' aimed at reducing patients' length of stay (LOS) in hospital and thus increasing surgical in-patient bed capacity. At the meeting were the Ward Manager, Specialist urology Registrar (SPR) and the care path co-ordinator who told us

for urology if the care pathway is started at pre-assessment and you tick the criteria a patient is suitable for hospital to home, then on day two of the TURP you could have the criteria listed and if they are all fulfilled they can go, if not it would be a variance and we can find out why they can't go home (Fieldnotes).

Managerialism in The Clinical Division of Surgery.

The General Surgery and Urology Directorate is a sub-division of the clinical Division Surgery. The Division's management team are colloquially referred to by Surgical Nurses as 'the non clinical management', a title which seems to have evolved from a conflict between the managerial agenda and the nursing agenda, as Primary Nurse Faith illustrates

I don't know what their agenda is, but I don't think they give support at ward level at all, you do not see any member of management come down and ask you about how things are. The only time you see them is when they're asking for beds ... you don't see them on the ward level at all ... and they're

very good at passing things down to ward level which they don't want to deal with [for instance] the Essence of care, audits which they should be undertaking, instead of physically coming round themselves they'll just pass it down ... we have taken on a lot of management issues ... the only time you see them is if there's a bed crisis and they want to move people NOW ... who physically and surgically aren't ready to be moved, and it doesn't matter whether they've got a consultant decision all they want is an empty bed at the end of the day ... (Interview: Primary Nurse Faith).

Powerful and constant messages emanate from the Trust Board and subsequently Divisional Managers, the more senior the clinical nurse the greater the response required to these messages. Two monthly forums exist where management messages are disseminated to clinical nurses, the Divisional Head Nurse and the DNM meetings; in addition to these formal arenas messages come to RNs attached to pay slips, via the telephone, in letters and memorandum, in the Trust magazine, via planned and impromptu ward visits and increasingly via email.

A Ward Manager took me to a room at the back of her ward she referred to as **the black hole where the paper mountain resided (fieldnotes)*, it was literally full of correspondence accrued over the previous months which she felt she could not dispose of because **it may be significant in the future (fieldnotes)*. After a day spent shadowing this Ward Manager I enquired about the content of the letters and emails she had opened that morning

They're directives, and it's duplication, a lot of the messages go to all the nurse managers ... clinical and non-clinical and they all seem to want to pass all their job, pass it all down to you. Now I've brought it up time and time again, you either get no communication or triplicates, it's about improving working lives and things like Essence of Care, and YOU MUST DO IT there's no choice ... you are told you are doing this, no consultation, very seldom consultation ... the DOH paperwork comes down through those offices, the working time directives but didn't really get anything, we had to find that out ourselves. It is hard, a lot of the information I tend to get through my own networks, if I really need to know I find out myself, the stuff I don't tend to need to know I get in duplicate, I honestly do not know, hands on heart - I don't know what their job description is, I don't know what they're supposed to be doing - if the girls are asked they don't know who they are - the only time we see them is if it's in a bed management capacity (Interview: Ward Manager Lucy).

The messages from management fall into two categories, the first and most powerful are the 'money, money, money messages', but not far behind are the policy, policy, policy messages. Whilst the Trust is spending a phenomenal amount expanding and upgrading the critical care Directorate all 'other' Directorates⁷⁹ in this clinical division are bedeviled with the drive for cost containment. Managers persistently draw to the attention of surgical nurses the need to contain the costs of surgical dressings and drugs they refer to as '*costing hot spots*', alongside there being a moratorium on 'all new work'⁸⁰ in the Directorate. A regular tactic used by management is what a Ward Manager describes as 'money shuffling', where money allocated by government for simple improvements to their ageing wards results in ward nurses being told the money has gone to 'bale out' other services, at a time when there are rumours there is an overspend in the Trust despite the Trust's managerial aims being expansion:

Monies for new work at the moment are on hold .. housekeeping money got diverted and the problem is I mean ... I haven't got nothing hard and fast and no evidence to support it but I think the money's being moved, because there's so much going on in the way of building work they've probably over gilded and there's not enough pennies to go around (Interview: Primary Nurse Beth).

The Ward Managers' budgetary responsibilities are mooted as around three quarters of a million pounds to run their ward, although the overwhelming view of the Ward Manager /budget holders is that they both save and generate money but **the ward and us don't benefit ... managers don't want to pay... they tell us to pay for it out of own ward funds (fieldnotes).*

On all wards a Senior Nurse has the added, important role of 'managing the ordering of ward stores', which they are aware has to be done within an ethos of cost containment. A Primary Nurse 'stores manager' when asked about being cost conscious responded assertively:

⁷⁹ orthopaedic, head and neck, general surgery / urology.

⁸⁰ **New Work:** a term which refers colloquially to ward developments eg the putting up of shelves, the installation of a new plug socket or the purchasing and installation of a new shower unit.

I am cost conscious ... I'm a wise spender on products and that sort of thing, I don't order luxury items like we used to, talcum powder and toiletries I don't order any of those sort of luxury items like we used to do ... (Interview: Primary Nurse Beth).

Whilst RNs are wise spenders, this is not enough because management want more, their philosophy is cost reduction through paying for ward developments with money generated by staff, and money donated by 'grateful patients' as a Ward Manager explains:

We've just done a sponsored walk, we've raised £500, now we phoned the [Finance Director] to see if we can put it into an account purely for us and we can't do it, not like we always used to have [he tells us] there's too many fraudulent cases going on, so they stopped it ... I've got £500 sitting in the office, now what do you spend it on, do you go for books, go for study leave - because I am so reluctant to go for equipment but this room here we've bought the paint, we're gonna paint it ourselves (Interview: Ward Manager Beth).

A recent edict from management resulted in the centralizing of 'grateful patient' donations into a 'surgical unit fund', the difficulties this creates are backstage as a fieldwork experience illustrates:

regarding the essence of care where ward staff and patients identified the need for a place where 'bad news' could be given, to achieve this we've done the sponsored walk, and a patient's relative has offered to do the painting up of the old store room and we were going to purchase a two seater sofa and some pictures from IKEA, now it's all on hold ... (fieldnotes).

The policy messages to RNs are all about responding to government targets to reduce surgical waiting lists, and avoiding the breeching of waiting times in A&E, which are 'absolute priorities' for Rodin's managers. Numerous government policies were cascaded down to RNs for either comment or implementation alongside numerous local policies including 'lost false teeth' and the 'renaming of the mortuary' during fieldwork. The launch of the Essence of Care (DOH 2002) was for Senior and Junior surgical RNs the last straw, as a new RN explained:

... it's a bit patronising this essence of care, it's what we're doing anyway, the care is already good, yes it is good, its like out of the textbook, it's very good [have you worked at any other hospitals ?] I've done agency shifts, and this unit has better care than a lot of other areas I've worked on... particularly due to Primary Nursing (Interview: New RN Pamela).

Because there was no mandatory government requirement to implement the Essence of Care the DNM and Senior Nurses put it on the back burner as they felt there were other numerous and more important priorities, and they were in agreement **care is good here (fieldnotes)*.

On the backdrop of the financial and policy priorities pervading the Trust the surgical RNs have evolved a culture of cynicism towards Divisional Managers which extends to the Chief Executive ... as one Primary Nurse illustrates following a ward visit by the Chief Executive:

The Chief Executive came down to the ward a couple of week ago and said he'd never seen my face before and he wanted to know how long I'd worked on Monet, he wanted to know what we are doing with our patients at the moment to improve patient care. While he was on the ward I took him into my bay to show him all this out here [points through window at building site] I told him about the noise I have to put up with at work everyday, and I said about the men working till after midnight, and we have to go physically outside and telling them to stop, and the workmen are looking into the bay, he advised us to get some sheer sticky stuff you can see out [of] but not see in but he didn't want to pay for it, he wanted it to come out of the ward budget. He was asking about staff vacancies, I told him we had three at the time, he said we can pay for your blinds from that spare money ... we said well that has to go on agency staff ... all he wanted to know was about these petty patient priorities ... then he kept on saying I've got to go, I've got to go, I've got to go to a meeting and his mobile phone kept on going and he kept saying yeah, yeah I'm on my way we kept him talking for ages, but he was just going over the same things (Interview: Primary Nurse Hannah).

Ward Managers are also cynical towards managers, as one explains:

I honestly do not know, hands on heart, I don't know what their job description is, I don't know what they're supposed to be doing, if the girls are asked they don't know who they are - the only time we see them is if it's in a bed management capacity ... if the bed management was left to the people on the ward no not everyone it's already done, I had an incident last year when I was acting up and the manager on call was extremely senior, [we had] big problems with beds, I was told to go round the unit, it was about 12 o'clock in the day to find beds but if people are on their way in for surgery, they were just turned back, now that wasn't my role, but my strings were being pulled. So I went round to see what beds I could make and yeah we made a few beds, you know if people were going tomorrow, could they go home with rapid response, could they go with a bit of extra support, but, why did I have to do that, that was a major issue, because they are putting people in bed management roles that haven't got a clue of what the clinical needs of these patients are ... at the end of the day I

came into nursing to nurse now I may not be hands on but at least I can identify with my patients, they know me, managers give me more hassle, more targets, more why isn't this done, why haven't you saved this much more money - and I don't want it - so the frustrations are - and be honest the way the management set up is at the moment I don't think it works. We've gone full circle, we've gone from nursing officers to I don't know what now we've got Head Nurse, Deputy Nurse in surgery there's too many tiers, there's too many - we've gone from one to four (Interview: Ward Manager).

It is not surprising this cynicism has evolved when the actions of the Trust Board indicate NHS priorities are in stark contrast to those of RNs on shop floor surgical wards; Beth puts the cynicism down to ambiguity, because managers provide contradictory messages:

.. its very different ... management say one thing and then the Trust itself says another which is totally at the opposite end [give an example] trying to get people into flexible working time, that realistically cannot happen you have so much of one grade with that much money, with that budget you've got to staff your ward safely and adequately but flexible working patterns yes which is fine, but, for instance you can't have people coming in at all different times of the day ... especially when they want you to look at overlap as well, so for instance I've got a return to practice nurse, she can only do two earlies per week which means the other member of staff has got to do two lates a week (Interview: Ward Manager Beth).

Even Junior RNs view managers cynically, but their focus is on the fact they were once RNs, a background felt to now have been left behind:

... managers are more business minded now, I think there's a lot of managers who get up there and haven't got the qualifications and I think how have they done that because they haven't got degrees and all that..... so, they don't think of us, what were doing, and they'll contradict themselves a lot, there's a big issue like, the ward manager wanted to do less days, two of them came up saying job share that's a brilliant option but then the other one is saying you cant have a job on shorter hours... now I think they should start singing from the same hymn sheet, because they all say different things ... they've almost forget what nursing is all about ... promoted to management ... there were other issues like, we've had a lot to do with management the last 12 months because, when we had such a bad shortage of staff and we were begging them to let us shut a bay because we were that short staffed, we had NO staff on the off duty and we were in pain, we were struggling, we had reams, pages of agency, and we asked please shut a bay, patient care was struggling, let us shut a bay, let us get back on our feet, they wouldn't have it, and that's when more people started leaving, because of the strain ... and the fact that, if they maybe had let us shut down beds, and we hadn't got so much to cope with, then we would have been

able to retain. But recruitment and retention isn't a priority (Interview: Associate Nurse Amanda).

The chasm between non clinical and clinical nurses is now so vast entire meetings where the two are present is dominated by Trust policy and financial agendas, whilst front line RNs sit in silence. Having come from an educational environment focused on critically exploring nursing, into a culture of silence regarding nursing in the clinical environment, this was an observation pursued with a Ward Manager, when I asked Why are Nurses silent in meetings ?

They're too frightened to speak up, they [non-clinical management] don't want to listen to what you've got to say, there's an element of 'I can't be bothered', because I think morale is low, I'm not saying everybody, but I don't think people are concerned about the welfare of nursing staff - any of the staff here - I know they've got these groups up and running the staff experience and patient experience but at the end of the day you've got to get patients in, the patients need to be cared for, with whatever staff you've got (Interview: Ward Manager Molly).

The need for RNs to cope with and respond to management's dominant agenda of policy implementation and cost containment results in these agendas dominating and silencing the Nursing agenda.

Within the Surgical Division a further requirement was to respond to government's critical care strategy (DOH 2000), but just like the Trust delayed implementation of the Essence of Care, they were also slow to implement the comprehensive critical care recommendations, their justification being **the Directorate has few examples of undetected patient deterioration (fieldnotes)*.

Eventually critical care implemented an 'outreach' service, manned by five critical care trained RNs; not only did they take the critical care agenda to mean implementation of 'outreach services', but they were quick to follow this with a cascade of other initiatives in the form of policies on 'minimum standards for ward patient observations', up-skilling training in cannulation, venepuncture and male catheterization, a five day in house High Dependency course. Additionally critical care forged links with the local university and were able to introduce into the student nurse curriculum a critical care module.

The final guiding edict for RNs within the Trust came when the Chief Nurse issued a five year Strategy for Nursing, comprising eight key areas for development and action listed in Figure 50, abridged in Appendix 29.

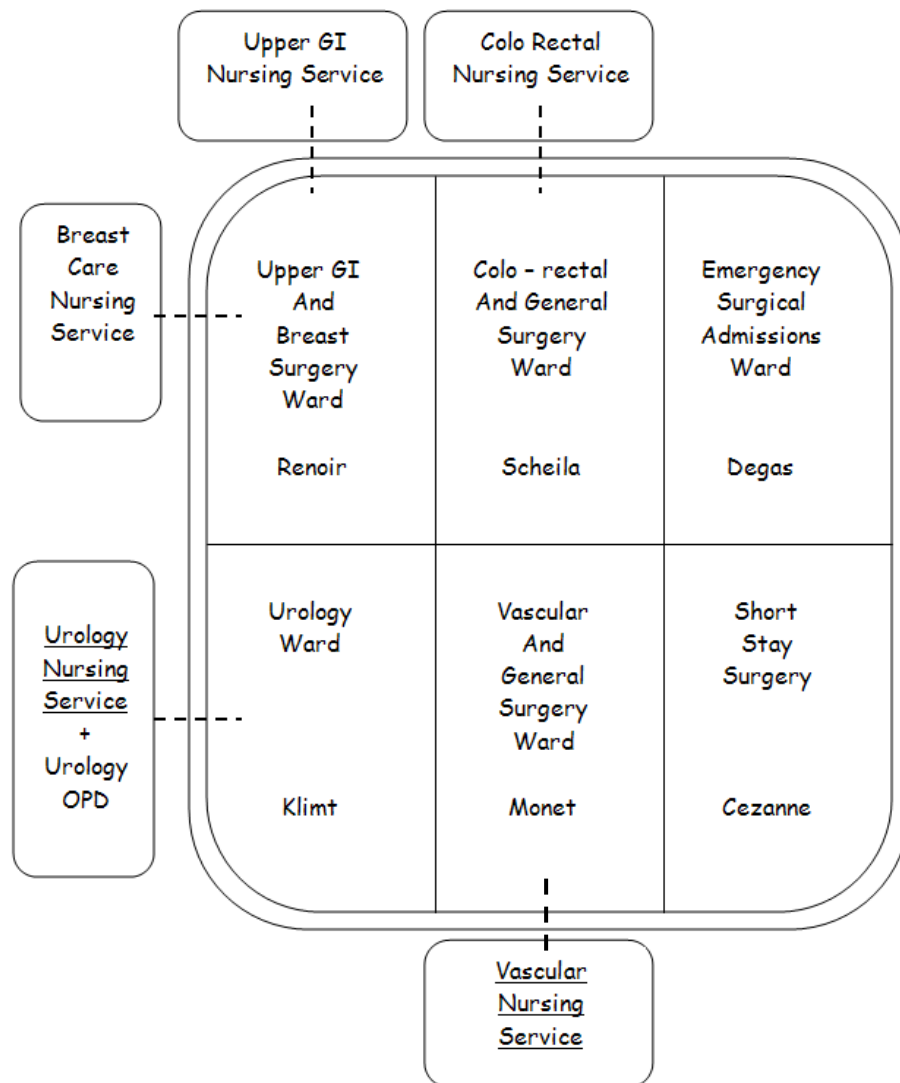
Figure 50: Resume Rodin's five year Strategy for Nursing (fieldwork document).

1. Recruit more nurses
2. Strengthen education and training
3. Develop a modern career framework
4. Improving Working Lives
5. Enhancing the quality of care
6. Strengthening leadership
7. Working in new ways
8. Nursing research and development

The General Surgery and Urology Directorate.

Having laid bare the managerial backdrop on which RNs practice, I now turn to describing the current day to day Surgical Directorate depicted in Figure 52. The business of the Directorate is described as **to provide surgical services for acute/emergency and planned/waiting list surgical patients (fieldnotes)*. Organizationally this Trust unit is one Directorate but financially 'General Surgery' and 'Urology' are administered separately, each headed by a Consultant Surgeon, the Clinical Director. General surgery has five wards with a total 109 in-patient beds with an annual budget of approximately 5.6 million pounds. Urology has one 27 bed ward and a urology out-patient department with an annual budget of approximately 1.5 million pounds, but in the 'virtual hospital world' is a 'hospital at home' scheme in urology, creating up to double the amount of surgical patients the urology ward nursing staff have to manage. Both General Surgery and Urology share beds on the short stay and surgical admissions wards.

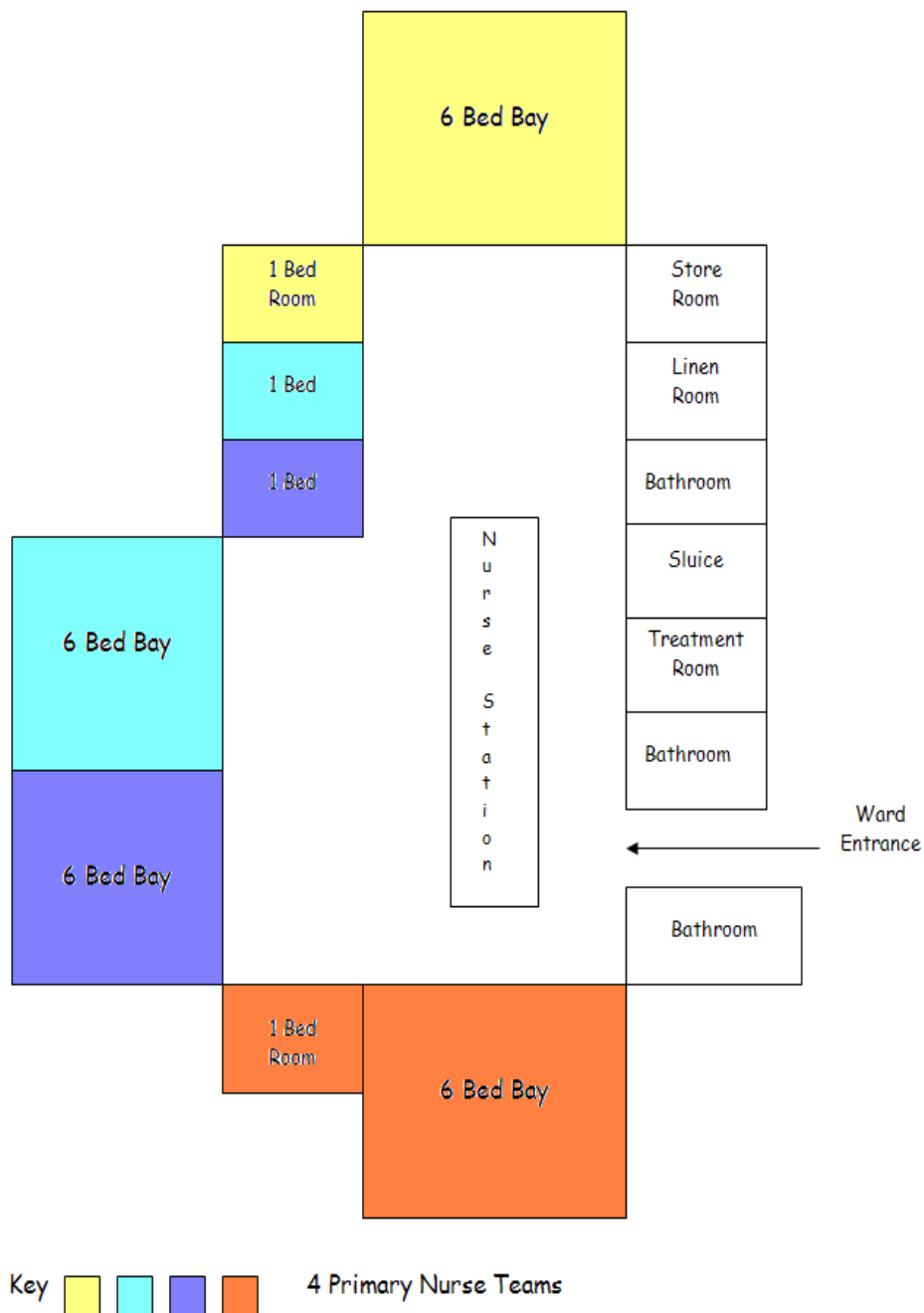
Figure 51: The structure of the General Surgery and Urology Directorate at the time of fieldwork.



The Surgical Wards.

The Directorate has six surgical wards, an out-patient urology department and five specialist nursing services providing surgical services for a local population of 400,000. Of the six surgical wards five share the same geographic layout shown in Figure 52, the character and business of each is now described.

Figure 52: Ward layout, colour coded by Primary Nursing Teams (from fieldnotes).



RENOIR.

Renoir is described by its Ward Manager as 'mixed speciality surgery', comprising Upper Gastro Intestinal (GI), Breast and General Surgery, a ward

whose surgical patients undergo life-changing major surgery⁸¹ because for the majority the underlying diagnosis is cancer. Regarding GI cancer patients an RN reminds us:

historically GI cancers are in older people and we have an older population now, so there are more people being operated on... and much bigger surgery ... we've got two surgeons who do three major operations, gastrectomy, oesophagectomy, pancreatectomy ... patients are in hospital, and dependent for quite a long time ... they need the support ... an Ivor Lewis⁸² you're looking at 10 days (Interview: Primary Nurse Denise).

The Modern Matron describes Renoir as

an excellent learning environment ... they are committed to keeping ladies [undergoing breast surgery] together in one bay ... they strive for early discharge of breast patients even if this means ladies still have drainage systems in place (fieldnotes).

Breast cancer patient care is celebrated throughout the Trust as an exemplar of best practice as one Specialist Nurse explained:

we have for a decade now pioneered early discharge with ladies with drains, these ladies have a choice, they can go home with the drain or stay, it depends on how they are (fieldnotes Specialist Nurse).

SCHEILA.

Scheila is locally known as the 'heavy bowel ward', its 28 beds are full of patients undergoing lower gastro intestinal (bowel) surgery, where the term 'heavy' describes the nature of bowel disease and bowel surgery being debilitating for the patient because often in this part of the country patients present with bowel cancer at an advanced stage⁸³, the surgery then renders them bed-bound and dependent on RN's for management of their every need. As Scheila's Acting Ward Manager explains:

I think we're the heaviest ward in the unit ... we've had agency nurses, who have done agency on other wards, come to us from other wards and they've said we're the heaviest not necessarily the busiest, but the most dependent

⁸¹ Life-changing surgical procedures: eg partial removal of the oesophagus (oesophagectomy), breast removal (mastectomy) / reconstruction.

⁸² Ivor Lewis: A major surgical procedure, removal of part of the oesophagus for cancer.

⁸³ as the population generally report changes in bowel habits late and thus present with more advanced problems as the disease is at a more advanced stage.

... but we don't get that much through-put but ... the dependency of the patients and the amount of tubes, bags ... and the amount of drips is a lot longer and the PCAs, I mean medical equipment library have said we use more equipment than any other ward in the hospital (Interview: Primary Nurse Grace).

With the recent addition of a fifth consultant surgeon the workload on Scheila has increased.

DEGAS.

Degas is the 20 bed Surgical Assessment Unit (SAU), organised into three six bed bays and two side rooms, which came into being for emergency surgical admission to reduce waiting times and to avoid breeching trolley times in the emergency department (A&E). Surgical patients are admitted directly to Degas via either A&E or GP referral, having been accepted for admission after a telephone vetting process by Senior RNs. The Ward Manager is very proud of RNs' achievements on Degas:

It's the third year we've been open ... it was set up for capacity management, set up to take pressure off A&E and existing surgical wards so we have all emergency admissions, it takes pressure off the other wards ... we can accept patients directly, we do nurse led acceptance of patients ... including from the GP (Interview: Ward Manager Molly).

On entering the ward there is a prominent whiteboard numbered 1 - 20, numbers which correspond with the beds on Degas. As a patient is accepted for admission their name is entered onto the whiteboard in red pen, signifying they are awaiting assessment by the 'surgical team', once seen by the surgical team their name is converted to blue, a colour coding system instantly revealing the status of each patient. To ensure a constant movement of patients from Degas senior nurses liaise with wards to 'move patients on' and free up beds for new admissions. The ward is a nexus of movement as patients are directly accepted by RNs from GPs, then moved on or out, with the final resort being moving beds around to ensure males and females are in separate bays.

MONET.

Monet is the vascular ward, which contains a four bed Vascular High Dependency unit (VSU), also a 'heavy' ward due to patients' reduced mobility as a result of lower limb circulatory failure. Surgical procedures range from major, high risk vascular by-pass surgery of the neck, abdomen and lower limb, to limb amputation and severe lower limb ulceration.

KLIMT.

Klimt specializes in Urology. The throughput on this ward is phenomenal because emergency and elective surgery admissions related to the prostate and renal system are common in society. To increase bed capacity a Hospital to Home service has been painstakingly developed; this involves patients for prostatectomy being pre-selected for early transfer home following surgery and a service developed and now manned by a team of Klimt's Associate Nurses who via protocols are able to transfer a patients care to their home, ring the patient at home at least twice a day, ask a set of pre-determined questions regarding their condition, and visit the patient at home to perform physical assessment and manage the process of returning them to normal urination⁸⁴.

The 'hospital at home' service creates a 'virtual ward' in addition to the real ward in Rodin, increasing the Acute Trusts capacity through adaptation of the computerised patient management system (PMS), which now reveals patients not yet discharged from the hospital but who are not in hospital beds because they are now being cared for in their own home. Thus the hospitals architectural boundaries have become modernized through use of the existing capable RN labour force /establishment⁸⁵.

⁸⁴ Prostatectomy patients often have a urinary catheter for the purposes of collecting urine whilst internal swelling reduces.

⁸⁵ At no additional cost to the Directorate the whole service is manned by the associate nurses employed on Klimt.

CEZANNE.

Cezanne is the most recent addition to the Directorates' portfolio of wards. Housed a fair distance from the main in-patient surgical wards it is a five day ward which opens its doors on a Monday at 7am and closes them at 6pm on a Friday. The patients whom Cezanne houses are not eligible for day surgery, and are patients who would have previously been admitted to a major in-patient surgical ward.

The ward manager is a dynamic RN who got her grounding in one of the major in-patient surgical wards, who alone has an edict from management to **accommodate a minimum of 25 surgical patients per week to maintain the service's viability*. A recent management audit demonstrated this was constantly exceeded, an astute junior doctor published the results of the audit concluding:

This is a new innovation ... a dedicated short stay surgical unit which attracts patients undergoing surgical procedures, which allows an efficient use of hospital beds, while still adhering to a pre-determined pre-admission care plan (Fieldwork document).

The Surgical Patients.

A phenomenal number of different surgical procedures were performed on patients in the Directorate during fieldwork. In addition to housing patients undergoing surgery patients are admitted who require conservative management⁸⁶, alongside a small number of patients who have previously been managed under the surgical umbrella but are now in advanced stages of their disease and require pain relief and symptom control because they are in the palliative and end of life phase of their disease.

As the incidence of violent crime (shootings and stabbings) and traumatic injuries continues to rise in Rodingham and because the Rodin is the only hospital providing acute services for this major city, victims of crime and accidental

⁸⁶ **Conservative management** - comprising administration of drugs / fluids, pain relief and observations for improvement or deterioration.

injury are commonplace patients in surgical wards, many of which are under constant police guard. Quantifying surgical activity in this Directorate is beyond the remit of this study but a snapshot of the routine surgical activities outlined in Appendix 30 provide a flavour of the surgical services RNs support in the Directorate for the local population.

The overwhelming view of both the Junior and Senior RN labour force is that over recent years surgical wards are busier and have more dependent patients, although RNs recognize it is impossible to compare wards, due to the different specialties bringing with them different types of dependency and workload. A regular pursuit of Senior RNs has been to report to management the ever increasing throughput of patients and their increased dependency. These messages from RNs at the chalk face to non clinical managers seem to **fall on deaf ears (DNM fieldnotes)* because the constant management reply is **show me the evidence (fieldnotes).*, but RNs tell me **we can't prove it, *but it takes four to turn a patient, *the case mix has changed, *but we can't prove increased dependency, *years ago we had Monitor⁸⁷ (fieldnotes).*

A Primary Nurse went so far as to estimate patient dependency had trebled ...

I've been here seven years and it's trebled. The dependency on the ward has trebled ... on my very first day on the ward as a student nurse, the beginning of my 3rd year I was in the yellow team and I'd got a lady in the first bed with a mastectomy, then a lady having an oesophagectomy, then a lady who had a hernia repair so those three had all come back from theatre, on the other side I had someone who had a hernia repair 3 days ago, somebody who'd had a mastectomy 5 days ago and then somebody who had some operation on her foot 5 days ago... they were completely self caring, I'd got 3 totally dependent patients and 3 completely independent, so you can manage a patient caseload when its like that now most of my patients are fully dependent ... with the increase in the big cases, with the hospital to home, reduced your length of stay and the new wards (Degas and Cezanne) the ward is raised, it's gone up massively the dependency [on other wards in the Directorate] is a lot different to the dependency of our patients, they're dependent in a different way... they're heavy because they're limbs, but they're not heavy in terms of the invasive procedures (Interview: Primary Nurse Denise).

⁸⁷ **MONITOR:** A patient dependency system used in the late 80's and early 90's.

To clarify issues related to dependency I pursued this with a Primary Nurse with over 10 years experience in the role:

dependency is greater without question ... I mean I can only speak for the ward I work on, we've got three colo-rectal surgeons, whereas we only had two, when I started there used to be three, four big cases maximum a week, majors, big cases [what are majors] ... bowel resection, stoma formation, an AP [abdo perineal resection of rectum], whereas now there's at least eight, and then there seems to be , I mean I don't have specific evidence but there seems to be more people coming in as an emergency as well, and I think people are surviving the surgery now, when perhaps they wouldn't have, even 5 years ago ... (Interview: Primary Nurse Grace).

The stark reality is that despite RN's having been continuously employed within this ever changing Directorate they feel they are unable to prove increased patient dependency and increased throughput of patients. Senior RNs recall when they used dependency monitoring systems on implementing Primary Nursing to substantiate their claims for quality care, today they are no longer permitted to use these quantifiable methods as the current DNM explains in relation to the sinking ship she feels she is currently in:

I have no opportunity to compare dependency yet in my experience of the changes over the years, the inception of the short stay unit has changed the bed occupancy on the wards, but all management perceive is the availability of two more theatre slots but we have increased the number of surgeons, therefore the workload that follows them in major cases is greater and so the nurses role with dependent patients is more Degas has become a 'holding bay', and is all about throughput, because they decant the patients to us, and Cezanne [the short stay ward] has less dependant patients (fieldwork discussion with Matron).

Not all patients in the Surgical Directorate wards are surgical patients, emergency admission to a ward too often depends on empty bed availability as opposed to medical specialism. Having followed the care for two 'medical outliers' they create a phenomenal additional workload for surgical nurses as fieldnotes of two medical outlier case studies illustrate, figure 53.

Figure 53: Two Medical Outlier case studies (Fieldnotes).

Peter and his partner Mike:

Tonight on the night shift, I worked with a new RN, in our bay we had a side ward with a young man at the end of life / terminal stage, his primary diagnosis was AIDS. He's been very restless, throwing the sheets off and trying to get out of bed, he was weak. His partner has been here all night, in a chair by the bed, we moved him each time we attended Peter. I enquired why Peter was on the surgical ward, I didn't feel it was the right end of life environment ... I was told he had AIDS related vascular disease, transferred from the medical unit and now couldn't go back, the hospice won't take him ... It's 4am and fairly quiet for the first time, I take the opportunity to write up these fieldnotes ... I find myself drawn back to thinking about Peter in the side ward, one of us has been in the room every five minutes since the shift started, we have to keep the door open because he's so restless, yet his partner is trying to get a little sleep, I just keep asking myself why is he in such a busy acute ward.

Anna a 'medical outlier':

Late shift and one empty bed, the only one in the directorate, A&E fills it with a young School teacher, with severe headaches and a 'blackout'. She's been admitted for observation, her fiancé and parents are here. We transfer Anna to a bay and start recording observations, she's pale and frightened, the overhead bed light... she cries out in pain. I look at the co-ordinator we know she's not a well girl. I take over the admission because the Primary Nurse is elsewhere, I do the observations and inform the Primary Nurse, we decide to call the medical on call team, two hour later they turn up During which I have dealt with Anna's distressed relatives, other patients and now the on-call team decide Anna needs a lumbar Puncture, only myself and the nurse in charge can assist

To capture current patient dependency I mapped ward patients on several occasions, one example being a night shift on a 27 bed ward shown in Appendix 43. The average patient age was 64, and the incidence of co-morbidity was high, several patients were extremely poorly with nurses in attendance almost continuously. A gentleman was in a side ward, unconscious with a tracheostomy and even though he was on a special bed to prevent pressure sores required four

staff to change his position every two hours, and an RN to respond to his tracheal suction needs on demand.

The medical provision of surgical services.

Just as nursing has a hierarchy of clinical positions, so does the medical profession. On exiting medical training, Junior Doctors' first year is spent at the House Officer grade undertaking a six-month medical and six-month surgical position commencing October and February of each year. Junior Doctors following a long campaign for improved working conditions at night have had implemented in this Trust 'Protected Sleep Time'⁸⁸, a policy resulting in the implementation of a Night Nurse practitioner service, who are now the first point of contact for ward nurses to ensure the junior doctor is not disturbed. The next grade of Doctor is the SHO, the now fully registered doctor pursuing a career pathway to either Consultant or General Practitioner. Then we have the Doctors who wish to pursue a career in surgery, appointed into surgical training posts, the surgical registrar and his more senior counterpart the Senior Registrar, more recently referred to as the SPR. Despite changes to junior doctor titles, terms and conditions and training we still have the most senior doctors in the directorate the Consultant Surgeons, who tend to be ward-based due to hospital ward sub-specialization, although due to bed shortages the consultant can find his/her patients scattered around in the directorate and beyond.

Consultant Surgeons do not seem to be a very happy group of professionals, there is a general feeling amongst Surgical RNs that Consultants trust neither Junior Doctors nor non-clinical managers, a situation which came to be confirmed during fieldwork as a result of experiencing RNs frequently ringing Consultants regarding concerns about direct patient care delivered by juniors, and concern regarding non clinical managers' decisions RNs knew would have

⁸⁸ **Protected Sleep Time** - time when the Junior Doctor on call is not to be disturbed.

repercussions when the consultant came to do his/her ward rounds, particularly in relation to 'getting in' surgical patients for the next day's operating list.

Ringling Consultant Surgeons directly, even in the middle of the night has become normal practice, as a Junior RN explains as a result of her feeling she was being put under pressure by an on-call manager to add patients to the consultant's next day operating list, which she felt was wrong because he had not been consulted about these changes:

It was ...that shift we couldn't get his TCI's in ... the Directorate manager had rung me and said get your TCI's in they'll come through SAU and I think they'd been on the waiting list before and they'd been cancelled and whatever, so I asked this E grade who was on what I should do, what the advice would be and she said if they're gonna be added onto Mr C's list then I think he should know, he's the one whose gonna be doing the surgery so I ended up ringing him at home which, he's actually one of the consultants where you can ring him at any time about one of his patients, he's absolutely fine about it ... yeah and Mr T you know as well ... and he said absolutely no, don't add the patients onto my list and how dare she ... it was his theatre time and he allocates what patients he has on his list and whatever, so as I say with Mr C you can just ring him at home, and there isn't any concern and I wouldn't be concerned anyway, if its one of their patients and I don't think things are right and his team aren't on call, or his Dr's aren't coming up to review the patient then (Interview: Associate Nurse Sophie).

Ringling the consultant directly when a patient's condition is of concern rather than going through the outreach service is a situation which has become increasingly evident on evening and night shifts, usually to override juniors' decisions, or lack of them as a Ward Manager explains:

that's because it's the same as student nurse training the house officers are as green as grass from medical school, the SHO's are protected in that they haven't got the experience they used to have - so I think if they know a nurse with some credibility is gonna ring them if the patient does go off, then they're more likely to come in. Yeah, even (...) in the last 2 years if you had a problem he would tell them to ring him - because with his experience you have this 6th sense that something might happen and that was - ring me and each one of ours actually does that (Interview: Ward Manager Molly).

I was curious to know why the Ward Manager felt this was occurring

It's almost as though [consultants] have assumed the same position as nurses ... they want to know from the Primary person rather than going through someone else ... Plus it's the fact it's the person they're gonna refer

to a registrar who isn't on the firm and we're so specialist now (...), I mean, I'm not saying anybody can look after a laparotomy by any means - but the inner bits, if someone came here with a funny rectal problem I wouldn't dream of ringing someone else and it's 5.30, so if we're specialising (...), the people upstairs are recto-colonic so I think from that point of view if we're worried about the patient rather than not mismanage, no that's not fair, but not go through, the maybe what they'd go through - i.e. if a blood pressure drops on here - on one of the vasculars we don't jump up and down that much about it - because we run them low ... whereas if it's upstairs and they've got a low blood pressure - they over infuse them and you're bursting through grafts ... so it's all to do with specialisms and I think they're much confident if they're actually - know about a problem and can relate to an SPR rather than the SPR getting there too early and maybe undo what they've done (Interview: Ward Manager).

This line of enquiry regarding ringing consultants direct was pursued with a Primary Nurse when I asked her 'Why do you think we're having to do that?':

In certain instances ... if you know the patient is going off and you know your consultant, and you know what they want done ... and you know that isn't happening I ring and he comes in (Interview: Primary Nurse Grace).

Finally regarding the medical profession in the Directorate, the Trust became a recognized training site for medical students, two years earlier than planned. During the preceding months RNs were assured the infrastructure for medical students was being put in place⁸⁹. The medical students arrived and no systems were in place regarding their ward experience, consequently this had implications for nursing staff in the form of having to change visiting times, advocating for patients because medical students were not fully consenting patients prior to examining them and their day starting at 10am after a lot of the work is done. A Primary Nurse described clearly the impact of medical students on her role:

they're a pain, because they want to know where the consultants are, where the teaching is taking place, and you don't know because you don't know what the consultants have organised [is that your job to tell them?] No, no, they know for only one of them to come - they've got [the consultant surgeons] four each and it's been a nightmare already, because they'll just ask whose a patient, whose got Peripheral Vascular Disease, that I can go and talk to those perhaps got a leg ulcer and like most of our patients are quite obliging

⁸⁹ which included increased resources in the medical library and appointment of a full time undergraduate medical education co-ordinator, paid for by the Deanery.

- you know, they're quite chatty people, they're not consenting the patient, all they say is I'm a medical student can I have a chat with you, their approach is inadequate to let the patient know enough as to what they are letting themselves into, and sometimes they want you to take the dressing down for them to have a look at and I say NO, already dressed it today. You'll have to come tomorrow morning at 9 a.m. I don't take it down for the consultant - let alone the medical student they are a bit of a pain (Interview: Primary Nurse Hannah).

The annual Deanery Visit was followed by their formal report which indicated the new deal on junior doctors hours was still non compliant within General Surgery (and General Medicine) the trust had indicating there was a plan in place to deliver this, the Deanery concluding **we suggest you do what the plan says (Fieldwork document).*

Chapter 5: The Surgical Nurse labour force and the conditions of production.

Enter any surgical ward on a weekday and you may well be as surprised as I was at the number of staff on duty, surprised because this is in sharp contrast to media headlines and RCN press releases which express concerns regarding the 'shortage of nurses'. After several weeks of finding my bearings within the Directorate, ward staffing was found to be an 'illusion', because the once exclusive and distinctive uniforms donned by RNs⁹⁰ have now been recycled and are worn by ancillary, medical records staff and contracted cleaners creating an illusion of well- if not over-staffed hospital wards. Although numerous uniformed staff are present on surgical wards the question turns to who are they ? On closer examination many uniformed staff are not part of the nursing establishment⁹¹, they are part of a transient workforce made up of Agency, Student and Return to Practice Nurses, a realization deemed a landmark in the study as this resulted in a simple classification of the Surgical RN labour force into permanent and transient RNs.

The Surgical 'Nursing' labour force.

The head of the clinical labour force is the Modern Matron, who is responsible for two groups of Surgical Nurses, those who are ward based and those manning the specialist nurse services. Ward based RNs include Ward Managers, Night Nurse Practitioners (NNPs), Primary and Associate Nurses, Junior RN's and the Nursing Auxiliaries. The two categories of Specialist Nurse who work Monday to Friday are Clinical Nurse Specialist (CNS) and Advanced Nurse Practitioner (ANP). The roles of each of these grades of Nursing staff in the surgical Directorate are now explored.

⁹⁰ The medium and dark blue uniforms traditionally associated with staff nurse and sister and the white uniform of the student nurse.

The Modern Matron.

The Directorate Nurse Manager (DNM) is the most senior clinical nurse, who under Agenda for Change (AfC) was initially re-named Head Nurse, swiftly followed by re-branding to Modern Matron, with which came a new uniform and a revised job description. After several months of being re-branded the well respected, experienced Modern Matron indicated **the job's the same, with bolt ons (fieldnotes)*. As the most senior clinical nurse the Modern Matron role involved visiting wards, appointing staff, distributing and enforcing policy, constantly investigating and responding to complaints, maintaining relationships with medical staff, and smoothing conflicts between medics and managers.

Over the six months following being re-branded, the Modern Matron increasingly viewed her role as untenable: **all management want is for me to put ticks in their boxes (fieldnotes)*, indicating on several occasions ** I've had enough of managers' agendas (fieldnotes)*. The constant stress of the role combined with flaring up of a chronic condition led to a period of sickness, the next thing we knew the Modern Matron took early retirement. On departing she described what she felt about the current role **I was caught between the devil and the deep blue sea (fieldnotes)⁹²*, **I've been the general dog's body for managers (fieldnotes)*. On leaving the trust she was cynical, informing me of her views of the current managers and government:

they're creating disempowered experienced practitioners, who are pressurised, squeezed and overloaded. I've been a scapegoat for management's decisions regarding staffing (fieldnotes).

The Ward Manager.

The Ward Managers, following an edict from the Trust board, and changes to their pay and conditions following the AfC review, are only allowed to work Monday to Friday. Their role is to manage and be responsible and accountable

⁹¹ **Nursing Establishment:** a term used within health care to indicate the agreed nurse staffing levels in the provision of clinical services.

for [in the eyes of management] a ward budget estimated at $\frac{3}{4}$ million pounds, although in the real world of the Ward Manager they know they have no control over the budget because **behind closed doors managers control the major costs (fieldnotes)*, the nursing labour force:

What we can't understand is, common sense tells us if somebody's left you've got a vacancy, you've got spare money, but money goes out of your budget ... It's as though it's disappeared and I tend to think, quite sensibly it seems to me, every three months they look at this budgeting and everybody goes into a panic and they say you can't have any agency, you can't have anything and it all goes quiet and then off it goes again, but in between monies are lost, I had a vacancy for an evening receptionist, that money has gone out of the budget and I didn't manage to get anybody ... the overseas nurses I didn't ask for they just turned up on the budget. We were told that we were training them for [critical care] and they were supernumerary anyway, but then suddenly there was some C grades monies going out of the budget and I chased it, because I said I've got no C grades and they were being paid C grades, now they're permanent, and I haven't actually agreed to this, no one discussed it with us (Interview: Ward Manager Kathleen).

Ward Managers voice uncertainty as to their budgetary responsibilities, and indicate they have undergone little or no preparation to fulfill these 'extra', deemed 'most important' financial responsibilities:

every month you get spreadsheets back, we're looking we're comparing last month's budget to what you've spent this month with the money they give you annually... we don't have anything to do with the money we're actually given, in fact that's all at the Business Plan side. We only know about money from spreadsheets. I break it down, the spreadsheets I get are non-pay and pay - and out of that you've got all your various grades, costing per annum, with the on-costs obviously. But I've only learnt through self-teaching. But the frustration is I'm never in at the beginning to say where and how much we've got to spend ... (Interview: Ward Manager Lucy).

As the most Senior ward-based RN, everything to do with the ward, from coping with sickness, maternity leave, policy, duty rotas, responding to complaints, and attending meetings falls within their job description. The Ward Managers are concerned non clinical managers' priorities are moving away from patient care:

I think it's because I've gone through every which way change, right through 20 years now as a Senior Nurse, so I've seen and accepted changes, but it's getting more and more stressful with the political agendas as it stands. I think it hits me more than anyone else here, more than the juniors, you tend

⁹² The 'devil' being management and the 'deep blue sea' being clinical services / staff.

to shield them, plus you've got the various personalities within the medical staff on here which needs - what's the word - need calming. So my role is ooh multi-faceted but everything in the Directorate at the moment is all to do with trying to hit targets, it's costs, cost effectiveness, efficiency, bed day saves, but to me things seem to be going away from the fact there's a patient in the bed (Interview: Ward Manager Lucy).

Combined with the financial and managerial responsibilities the Ward Manager is the most clinically experienced surgical nurse on the ward, the reality is that when on duty, and on the ward, they are very visible within their wards undertaking ward rounds, passing on and making changes to care, updating staff on care requirements, monitoring patients condition and helping juniors to manage their role. On many occasions you find the Ward Manager delivering direct patient care and informing patients and relatives about 'what's going on' and supporting Junior Doctors.

Although the Ward Manager holds the dual role of Manager and clinical expert, the managerial role always takes priority, as a result of having to sort out day-to-day staffing, and dealing with deficiencies in other services, for example shortages in the availability of linen or pharmacy supplies. Overall this most senior, Ward Based clinical nurse's role is dominated by managing and smoothing out the 'Politics' of health care:

... it's a very difficult role and if you really sat and thought about it you'd think what the hell do I do because from the time you came on duty you're looking at the staff you've got and you know how much input you've got to put into each bay, where there is more junior staff or to me there's someone you don't feel confident with, and that takes up quite a lot of your time and you've got all the other issues as well going on, and I try to dip in when we've got other consultants or Dr's coming to the ward to make sure I'm available, so I know what's going on and know what information is around and I can pass that on to the nurses, the patient, the relative ... I feel I've gotta know, then whoever contacts me, and the other thing is I've always been a great believer in when any other consultant or doctor comes to this ward, then if I have a mental idea, that Dr so and so is going to come on, then I can say hello Dr so and so, you've come to see Mr so and so they think wow she knows what shes doing and that's very simple to do, but, there's a lot of wards where our Dr's have gone, and been completely ignored and nobody knows them and they've actually walked off without seeing the patient so its something I feel is important ... It's everso simple but it

has an effect It is just something I believe in, it's about standards ...
(Interview: Ward Manager Kathleen).

A major backstage dimension of the Monday to Friday Ward Manager role is bed management⁹³. The To Come In (TCI⁹⁴) list is housed at the nurses' station on a clipboard, and is treated by staff iconically within the wards. All queries regarding planned surgical admissions come to the ward, the Ward Manager grabs the TCI list, keeping it up to date to reflect agreements and changes with surgeons, anaesthetists, patients, relatives and the Consultant Surgeon's secretary. The Ward Manager's capacity management role comprises managing the in-patient beds (admissions and discharges), managing TCI patients, filling gaps due to cancellations, responding to pre-assessed patient problems through liaising with consultants, moving beds around to convert a male into a female bay, and in a crisis arranging early patient discharge in an effort to accommodate new patients. Ward Managers are constantly juggling beds and ringing patients at home to delay their admission until later in the day:

On one morning shift the Ward Manager is in her office ringing patients at home explaining she's trying to get them in for their surgery explaining diplomatically the bed situation (fieldnotes).

The bed situation regularly reverts to crisis management where the Ward Manager can be found ringing medical wards to re-house medical outliers so the waiting list surgical patients can be admitted because **blips in medical admissions creates major problem (fieldnotes)*.

On one day there were 17 medical outliers housed in surgical beds. On Cezanne, the short stay ward, the Ward Manager showed me how at short notice she puts patients on the TCI list to ensure full capacity of the operating theatre slot:

I've puts patients on the list by assessing their suitability, selecting them when we have a gap, a cancellation I've done that once or twice at short notice when the patients cancelled at the last minute, I've put replacements on ... the consultants said find me a suitable hernia ... and I've actually gone

⁹³ **Bed Management:** colloquially termed 'capacity management' and 'the ability to bed elective work'. which is all about management's achievement of the government targets for waiting list surgical patients and not breaching A&E waiting times.

⁹⁴ **TCI List:** This is the planned list of waiting list surgical admissions.

up, gone to his books and fortunately the notes have been there in the department and I've actually gone through the notes to find about SUITABILITY - for a short notice admission, starved and I rang them up. [going back to the word suitability could you explain] sometimes patients are being sent for pre-assessment clinic and some of them aren't suitable and it leads to cancellation, they're inappropriate, it isn't the idea of pre-assessment ... that decision should have been made beforehand, by going through the notes and saying yes we'll get this patient up this week for in 3 weeks' time between we can sort them out ... I spoke to the one consultant last night because I know he does his books, picks his patients out on the Monday or Tuesday for the following Monday, so he's gotta pick these patients out, and the girls, they're not picked out till late Monday, so its Tuesday before the administrative sides done and they won't get their letter till Wednesday, they've got to turn up for a clinic Friday and that is when the patients cancel, and those patients have already been given a theatre slot and it's too late Friday to fill ... (Interview: Ward Manager Beth).

Ward Managers are adamant bed management has always been part of their role, and an important one not fully appreciated by managers, who when they are on call turn up on the ward and superficially attempt to sort out beds. The Divisions on-call manager rota is prominently displayed in each ward; on a shift on Degas, the admissions ward, the on-call manager visited and pointed out there were eleven more patients than beds, and proceeded to state have you done XYZ to the Ward Manager, she then pronounced additional details on beds around the Directorate, in the form of a lecture. The Ward Manager knew this already because part of her role is to ring other wards to update the bed situation, yet suddenly it appears there are beds, but as the Ward Manager and her colleague the Primary Nurse try to point out two minutes earlier there were no beds. I was puzzled about the difference between the Ward Nurses' and the non clinical managers' perspective on bed availability across the Directorate, but as the Ward Manager points out:

they're not available yet and if you use the trauma orthopedic beds there will be no beds for the emergencies later, but they come and ask have you done XYZ, they're just stating the obvious, of course we've tried those things, if we can't find a bed it's not from want of trying (fieldnotes).

The Night Nurse Practitioner (NNP).

Until recently the Directorate's surgical wards were covered throughout the night by either a Primary Nurse or a Night Sister⁹⁵, with one or the other based on one surgical ward, overseeing care on the adjacent ward. As a result of implementing the EWTD for Junior Doctors, Night Sister posts have been reconfigured into the Night Nurse Practitioner (NNP) and Primary Nurses are confined to working only day shifts, providing management with an opportunity to reduce Senior Nurse Night Duty cover, reducing labour costs in the form of special duty payments. The new night cover arrangements moved from one senior nurse covering two wards, to one senior covering six wards.

To operationalize the NNP role there was mass up-skilling for Night Sisters which commenced with the issuing of a policy on 'verifying an expected death', and training by a consultant physician to fulfill the role, followed by venepuncture, cannulation, ECG and male catheterization up-skilling. Additionally a policy was issued whereby the NNP became the 'first point of call' (transcribed in Appendix 32) for Ward Nurses, simultaneously Junior Doctors were issued with an 'out of hours' policy, followed by NNPs being required to operationalise a protocol related to their re-branded role shown in Figure 54.

A new NNP explained why her role had changed from being a Night Sister:

On night duty the House Officer has protected sleep time from 1 a.m. to 6 a.m., but the SHO is on all night because this is their normal shift, they are then off tomorrow, from 6 a.m. we can call the House Officer. After 1 a.m. all the calls that may require referral to a doctor have to come through the surgical NNP (fieldnotes).

From shadowing NNPs I experienced their role first hand, their *modus operandi* on coming on duty was one of interrogating the RN in charge of each surgical ward, the aim being to find out **the bottom line on patients and staffing ...*

⁹⁵ **Night Sister:** Permanently contracted to undertake night duty.

basically the status of the ward and the overall situation in the Directorate (fieldnotes)

Figure 54: Night Nurse Practitioner Protocol (fieldwork document).

Start 20.20: Collect bleep, check diary for messages, tell switchboard NNP name and bleep number. Liaise with medical NNP for overall picture of hospital.

Take report and assess each ward for the support needed re: post operative patients, ill patients, staffing levels, bed availability.

Support each ward as appropriate: IV's, problem solve, liaise with Doctors, undertake night rounds, manage pharmacy needs, conduct ward work as required.

Base yourself where most appropriate ie: the busiest ward, or with the most junior or agency staff.

Respond to:

- Major emergencies
- Crash Calls
- Emergency situations
- Enquiries to medical staff
- Clinical enquiries from staff
- Liaise with HDU / ITU
- Death Verification
- Venflons, ECG, Male catheterization, Venepuncture
- Pharmacy needs

At the end of shift: Write up diary, leave messages for other NNPs, including problems and recommendations, requests, incidents. **Finish 08.00.**

which they see as essential for managing a fire, coping with a major influx of patients, or if called to a crisis, as a fieldwork experience illustrates:

Tonight I met the NNP as she came on duty, there's only her to cover all the wards. We start with a tour of the wards she tells me 'I find out the following information so I get an overall picture of the situation'. She tells me bed blocking is a major issue, and that she sometimes has to physically walk around the wards and identify the ACTUAL number of beds occupied, because it's a fire risk to not declare beds and I am responsible at night, staff naturally don't tell us head counts i.e. empty beds due to home leave, or on HDU/ITU - I wouldn't use these beds unless I specifically had to but I need to know patient numbers. I have to make a decision who will need help - where I have to spend most time, I'm not specifically allocated to one ward but because I came from Sheila I tend to have that as my base.

After the initial fact-finding survey of the wards the NNP does a second round, on Rodin the Junior RN tells us there are 16 nights this month when the ward is manned by only one regular RN. The Junior RN is in charge tonight and the NNP discretely tells me **she's struggling tonight because the other staff on duty are employed at an assistant grade from the agency, none of them can administer IV drugs;* it is now 23.20 and this solitary regular RN commences preparing and administering the 22.00 IV antibiotics.

A Ward Manager voiced concerns about the skill mix changes on night duty, and how this has impacted on the NNP role:

it worries me, I used to pride myself in the fact I'd always got an Associate or Primary Nurse on night duty, because you know and I know anything can happen, and I might be here in the day overseeing but night time's a sensitive time ... I'm putting a lot more post-op patients in the [high dependency bay] which I necessarily wouldn't have done before because I've got 2 or 3 junior staff on the ward at night with a floor sister, patients go off, outreach come and floor sister hasn't been told, the NNP has absolutely been mortified ... I haven't got a problem with the floor sister but I think they should be ward based, they have five wards, and its totally impossible ... I don't understand even to this day where it all emerged from, I know [the Modern Matron] was quite concerned ... how it got from there to here I just don't know, I don't know how it evolved and we've had no replacements for the person they took off us (Interview: Ward Manager Lucy).

The situations NNPs deal with include being called to resite drips, manage beds, investigate reported intruders, and generally ensuring ward staff safety because the surgical wards are housed just off the main hospital corridor and adjacent to the emergency department. The bleep goes off again and we are off to Degas ... this time the request is for a cannula to be inserted:

The NNP is called to SAU to cannulate, there's a Doctor on the ward but she's busy with a new admission. The Staff Nurse who called the NNP tells us she has done the cannulation course but has never practised this and so doesn't feel confident to do it, she tells us she's forgotten what she was taught, the NNP takes this as an opportunity to go through the procedure with the Staff Nurse (fieldnotes).

In addition to the NNPs routine work, there are also emergencies they are called to as the 'first point of contact' ... the bleep goes off for the first time

and we are called by a Junior to Renoir who requests assistance because a man seems chesty:

We arrive on Renoir and are pointed in the direction of a gentleman who on approaching him we can hear his difficulties breathing, the NNP takes one look whilst myself and the Staff Nurse begin caring for the gentleman the NNP immediately calls for the outreach team as a matter of urgency, they're there in seconds, a nurse a registrar and an anaesthetist... the patient within 20 minutes is transferred to HDU (fieldnotes)..

By the end of the night shift the NNP has been called to see several patients by Junior RN's, the NNPs views on this are explored

What I'm noticing is that they're [the Juniors] right to call the NNP because they're concerned about a patient, but they're unable to provide a comprehensive picture of the patient - they can't contextualise the patient's history - number of days post-op, medical details - so the first job is to 'look at the patient' and then ask the Junior lots of questions, straightforward questions like : Operation, Number of days post-op, What like before ... Then I usually have to look through notes, look at blood results so she can come to some clinical decision (fieldnotes).

This situation was seen time and time again, with a perplexing effect on the NNPs.

The Primary Nurses.

The Primary Nursing labour process has been embedded here for 15 years, the term 'Primary' referring to a person of 'chief importance', and a particularly pertinent term because the Primary Nurses⁹⁶ are the custodians of 'the quality of surgical patient care', and are also the role models for quality care because they are the deliverers of direct patient care. They assess patients' needs, plan care for others to follow [in their absence], deliver the expert care required to meet individual patients' needs, evaluate the outcomes and make appropriate changes, passing on their expertise through their roles as mentor, preceptor, supervisor, teacher and assessor across a broad range of staff on the surgical

⁹⁶ Prior to implementing Primary Nursing, this grade of staff were titled Junior Sister.

wards⁹⁷, through role modeling, they are an all degree labour force in this Directorate.

As a Primary Nurse explains, her role is one where 'the buck stops' regarding individualized patient care:

because you're a Primary Nurse you're expected to know, I was saying to [...] the Ward Manager yesterday, because it was my appraisal ... that when you're an Associate Nurse and when you've got that Primary Nurse in the bay you sort of, you don't fall back and think someone else will do it, but, you've always got that bit of support there for yourself, whereas now since I've had this Primary Nurse post a couple of months and it's sort of hitting me now, the buck stops, I've got to sort it out, although I could go to [the Ward Manager] and say... what do you think of this and she's there, but the fact that you're in your team and you're girls are coming to you, your juniors it's all my responsibility (Interview: Acting Primary Nurse Sophie).

The number of Primary Nurses is declining because if one leaves management put a freeze on the vacancy so Ward Managers place an Associate Nurse into this post in an 'acting up' role, a position which leads the Associate Nurse to an acute awareness of the additional responsibility:

being the Primary Nurse at the moment, you feel responsible 24 hours, not a worrying responsibility, but you know your responsible. I've left messages knowing that I won't be back till Friday for my staff so they can take over where I left off, because I know things won't have been done, and I'm aware of that, I'm aware I'm accountable (Interview: Acting Primary Nurse Eloise).

The Primary Nurse role is pivotal to quality patient care but as Denise explains, because the numbers of Senior RNs on each ward are dwindling, those remaining find themselves increasingly being 'pulled further from their patients', a situation 'worrying' Denise because the wards are increasingly staffed with juniors, so she is increasingly finding herself checking up on staff when in charge:

I recently found a junior trying to administer blood to the wrong patient and they were going to put it up and they hadn't checked the blood with anybody else and they were going to actually put it through a normal giving set through a pump ... I've noticed problems... silly things, but things that matter to patients like mouth care, patients who've got oesophageal cancer who

⁹⁷ Student Nurse, adaptation nurses, return to nursing, work experience.

can't even swallow their own sputum, well they can't bring the sputum up, they can't even swallow their own secretions if they have no mouth care ... and not writing down bowels open, patients who have not had their bowels open, but nobody has actually addressed that ... standards do vary, standards vary between each nurse, I think that's one of the roles I've got, it's my job to make sure it doesn't vary in my bay... that every single patient gets the care ... they've had their bowels open or not, mouth care has been done and that's the difficult part ... because it tends to get me angry... I think basically that we've got to achieve a high standard with the minimal amount of resources, and that we've got to be happy, with our lot, that what the [Chief Executive] wants us to be, the happiest hospital in the world, but he doesn't want to give us any parking spaces, or nurses, it's more for less and he just wants us to be happy, but they don't want to make us happy by listening to us ... at the end of the day the managers aren't nurses and that's the main thing ... even the one who was a nurse I think they have forgotten, they've forgotten what it's actually like to come on a ward and wash someone ... I'd much rather manage patients, and my patients be happy, happy with the care they've got (Interview: Primary Nurse Denise).

Recently the Trust introduced a one year Primary Nurse development programme, comprising a set of competencies, acting up responsibilities and an assessment framework, described as:

to enable the development of new skills in order for the Primary Nurse to confidently make the transition to Ward Manager (fieldwork document).

although Primary Nurses view the programme as more management rhetoric than reality as none of them have any experience of the programme being implemented.

The Associate Nurse.

The Associate Nurses are the deputies to the Primary Nurses and the 'inbetweenie' RN labour force, thus called because they are sandwiched between the Junior and the most clinically capable RNs. The Associate Nurse posts are another grade being dwindled down through management's freeze on vacancies, then converting these positions to junior grades. The position is unappealing to the capable junior RNs mainly because they feel there is little remuneration for the extra hassle when they can earn the same doing an extra agency shift, a Ward Manager explains:

trying to get Associate Nurses is an absolute nightmare ... [the juniors] don't want the extra responsibility, there's no incentive, their salary is good, I mean they go from a bursary to a salary with enhancements for night duty and weekends, they're quite happy with their lot ... there's not a lot of financial incentive to step up to an Associate Nurse ... and get a few hundred pounds, that's all, so that's pennies a month, and they can do one night on the agency (Interview: Ward Manager Lucy).

The Associate Nurse role comprises one of being capable and versatile in terms of patient care on a minute to minute basis. They need to be able to cope with the majority of ward situations they are faced with, whether these be poorly surgical cases, emergency admissions, unanticipated staff sickness or difficult relatives. They need to do this with confidence and competence and be able to prioritize the situation and direct others in the performance of their role, because their role involves taking charge of the surgical ward for a span of duty, particularly at the weekend and when staff are on holiday, maternity or sick leave.

The Associate Nurses have a 'get out clause' when faced with issues like complaints and personnel problems, things that can wait till the next shift or after the weekend, they can defer dealing with the problem until the Ward Manager or a Primary Nurse is available. But what the Associate Nurse can't get out of is having to deal with the immediate, unpredictable crisis which can often happen on a surgical ward, although there is usually support for them somewhere in the directorate [at night the NNP, in the day a nominated Senior Nurse] usually on another surgical ward. To be appointed into this role the RN is required to have undertaken and passed the statutory mentorship preparation, so they can be responsible for an allocated student nurse.

There are some opportunities for promotion to an Associate Nurse, and the odd one or two RNs come forward and are ready for this as Amanda explains:

I'm sick of being in charge on night duty and not getting paid for it. It's a practical thing, but the thing is I feel I've progressed and I feel happy, happier, I would stay at D but why stay at a D, if a job hadn't come up, at the end of the day if, if I didn't feel ready, you know, it's the fact I have to do it anyway ... (Interview: Newly promoted Associate Nurse Amanda).

Some Ward Managers experience a dilemma regarding the quality and experience of some Juniors being promoted to Associate Nurse:

It does concern me ... I've known people get Associate grades and I have said I am concerned, I've said I don't want them to be in charge on nights because things happen at night, the promotion seems to be a carrot .. we're doing it at the moment to retain staff ... but as to whether they've got the skills for the wide range of situations they could be faced with is something else ... (Interview: Ward Manager Beth).

Beth explores this further, explaining in more detail the keenness of some juniors for promotion:

... some juniors are very keen to get their Associate role ... they're very keen to get it and to have that responsibility ... but ... I mean in Primary Nursing you can be an associate on duty and not actually be in charge ... because you've got a more senior mentor ... but what they don't realise there will be days when they might be totally dropped in it ... and they just can't cope ... haven't got that experience and the prioritising skills ... the managing the ward and all grades of staff ... even down to the ward receptionist so people aren't time wasting... so they can still be in quite a protected role as an Associate, but not always, there's always that potential ... and this is what they just don't realise (Interview: Ward Manager Beth).

The Junior RNs.

The most Junior RNs in the surgical wards are those who apply for vacant posts and obtain a permanent contract of employment. The new recruits are allocated to a particular surgical ward, and to a Primary Nursing team responsible for the total management of seven surgical patients, with the Primary Nurse acting as their preceptor. Overall the Junior RN's role is to care for a bay of seven patients in the Primary Nursing system, and over time they oversee an adjacent bay because it is staffed by either an agency RN or an assistant grade. Finally the Junior is left in charge of the ward particularly on night duty and during an evening shift where they find themselves managing the whole range of ward situations faced by the more senior RNs.

The 'specialist' surgical nurses' and their services.

Specialist Nurses like the Modern Matron sit outside the day-to-day running of the in-patient wards. There are two classifications of Specialist Nurse, the

Clinical Nurse Specialist (CNS) and the Advanced Nurse Practitioner (ANP), the distinction being educational attainment; to be an ANP you must have an MSc and to be a CNS you must have a first degree, with those currently studying for their MSc telling me **I can't have the title or wear the uniform until I've got the Master's (fieldnotes)*. Most specialist nurses work part-time and their roles are organised around a diagnostic related group⁹⁸ (DRG). The specialist nursing services have expanded as a result of the Trust's focus on improving cancer services as an ANP explains:

We offer a Whole Patient Service we accept new suspected cancer patients, we make and become the patient's point of contact and were involved in their diagnostics and treatment, including the giving of bad news. Increasingly we are producing evidence for the audits and the cancer review We do this for the consultants ... We also monitor the patients on the wards (fieldnotes).

Having shadowed all the specialist nurses it was clear they packed lots into their working day, ranging from developing protocols, running nurse led clinics, responding to cancer service changes, providing continuous access for patients and relatives before diagnosis, during treatment, after discharge and through the palliative and terminal stages, including care for family and friends post death their weeks are full of many and varied activities, outlined in Figure 55. The Trust certainly gets it's monies worth from the specialist surgical services and the RNs running them.

The Assistant labour force in the surgical wards.

This Trust spent it's Project 2000 replacement monies on additional RNs within the Surgical Directorate, allowing them to implement Primary Nursing, subsequently there are only one or two Nursing Auxiliaries on each ward, the majority of whom have no formal training, but have been in the Directorate for a long time, one Nursing Auxilliary tells me **i've just received my 25 years long service award (fieldnotes)*.

⁹⁸ **Diagnostic related group (DRG):** Upper GI, Lower GI, Urology, Breast care and Vascular.

Figure 55: A week in the life of the Specialist Nurses'.

All the specialist nurses run clinics, usually on their own so they are Nurse led, they all undertake specialist investigations eg in the urology department they examine the prostate gland ... a lot of their work is part of the Cancer Strategy (driven by Calman Hine) hence they are the first point of contact for newly referred patients from the General Practitioner. They book patients in for the next clinic if the patient has a 'suspicious' diagnosis ... They see the patient and usually their accompanying nearest and dearest ... then it's all about investigations and history taking ... they then co-ordinate the results of the investigations, in the meanwhile they are often in contact with the patient, answering questions at this sensitive time.

MDT meeting, they are in attendance ... Often preparing the paperwork for the meeting, and liaising with the consultants regarding the decisions made ... Then reporting back to the patient ... and often meeting with them again if the news is not good, and follow up treatment is required in the form of surgery, chemotherapy, radiotherapy or for some end of life care. The specialist nurses are the 'main point of contact', the co-ordinator of care at this stage.

They also run follow up clinics, seeing patients who have undergone surgery ... Checking blood results and responding to any queries, needs of patients and relatives for information ...

All the specialist nurses have patients who are now in-patients, so they visit the ward on a weekday ... here they re-assess the patient, make changes to treatment / management and report concerns to ward nurses and the consultant, all of which they record in the patient's notes (as opposed to the nursing documentation), for some patients they begin the process of teaching / education eg the lower GI nurse teaches the new stoma patient all about the bag ... Over the next few days the process leads to the patient assuming responsibility for their own stoma.

A considerable number undertake Home visits, for patients following discharge from hospital ... They keep the consultant informed and where need be enable smooth readmission for additional care (from fieldwork and interviews).

This labour force are 'floaters' in the Primary Nursing system, when on duty allocated to the heaviest bay to assist the RN. They are an always busy labour force, when not feeding and washing patients their time is spent housekeeping and generally their presence within the vicinity of patients is continuous for their shift.

There are moves in the Trust to develop NVQ prepared assistants to support RNs, the NVQ project leader presented an overview of these developments at a Ward Manager meeting and asked for one RN from each ward to be sent on the NVQ D32/33 assessor training, subsequently each ward nominated an RN, only to be informed places had been given as a priority to non-clinical areas and that they would be in touch in the future (Fieldwork documents).

A further labour force Ward Managers were requested to introduce into their ward team are 'Ward Assistants', again via letter informing them **this had been agreed at a Divisional Manager Away Day (fieldwork document)* although the first the Ward Managers knew about it was when the letter arrived attached to which was a Job Description summarizing the new grade's proposed duties shown in Figure 56, indicating **the appointee would be accountable to the Ward Manager but professionally accountable to the head of Hotel Services (fieldwork document)*. The role was discussed at the Ward Manager meeting and a response sent to the Divisional Manager indicating they were in principle in agreement with the role only if it was **in addition to the existing Nursing Auxiliary, not in place of (fieldwork document)*.

Each ward also has a part-time Receptionist, a key player in the smooth running of the Ward; her role is both front and back stage, operating from her base, the Nursing Station within arm's reach of three telephones, the patients' notes trolley, two computers and the mountains of patient related paperwork that needs filing. Their duties range from welcoming new admissions, showing them to their bed and checking the accuracy of the patients biographical data, to

Figure 56: Summary of Job description / key duties of the new Ward Assistant grade (Fieldwork document).

Job Description.

The ward assistant will be required to undertake a range of duties associated with the upkeep of the ward environment and to maintain the highest standards of cleanliness. They will also be responsible for the giving out of meals and drinks to patients and ensuring menu choices are completed and communicated to the appropriate department. As part of the ward team he/she will support the delivery of patient care by nursing staff.

Key Duties.

1. To monitor the ward environment making sure areas are kept clean and tidy and to ensure standards are maintained and if not to take appropriate action (this includes flowers, up-keep of notice boards, bathrooms, communal areas).
2. To ensure all ward general information including patient leaflets and comments, suggestions and complaint forms are kept fully stocked, tidy and available for patients at all times.
3. To distribute menus and assist patients in completing them, in conjunction with the appropriate nursing staff, taking into consideration any special dietary requirements or other factors eg ethnic origin or religion.
4. To serve and distribute patients' meals, completing any relevant paperwork as required by the Senior Nurse.
5. To assist in the feeding of patients as necessary, under the direction of the professional nursing staff, after appropriate training.
6. To record the temperature of meals prior to meal service, in line with current food safety regulations.
7. To prepare drinks, snacks etc, and distribute to patients, including the provision of clean drinking water.
8. To wash patients' crockery as and when required and ensure the ward kitchen is kept clean and tidy.
9. To clean the ward fridge weekly, monitor and record the operating temperature daily and report any operating difficulties to the Senior Nurse.
10. To wash beds, mattresses and lockers following patient discharge. To clean patient bedside lockers and tables 3 times a day.
11. To undertake fire precaution and health and safety checklists daily, report ...
12. In conjunction with Senior Nurse be responsible for ordering of stores held at ward level eg catering, CSSD, dietary supplements ... Also ensure all storage areas are kept clean and tidy.
13. To clean any medical or other types of equipment, including oxygen points ... Report faults and discrepancies.
14. Comply with all relevant Trust policies and procedures.
15. Be aware of own responsibilities re H&S and comply with Trust policy ...
16. Attend mandatory and / or other training courses as required.
17. To participate in the Trust appraisal process.

fielding all phone calls to the ward, making appointments, booking transport, liaising with other departments on ward maintenance requests, and supporting Junior Doctors who are floundering in their new roles regarding the systems they are expected to master on the new and unfamiliar wards. The duties of the Ward Receptionist are non-nursing duties and the importance of their role, and the amount of work they do, only comes to light when they are on annual leave, or off sick, because there is no backfill into the role, RNs fill the gap.

Staffing the surgical 'Nursing' services.

In the Directorate, after what the Senior Nurses tell me has been a decade of staffing stability they are now faced with a constant 'cycle of staffing changes' as a result of RNs leaving. A significant factor impacting on surgical ward staffing has been the recent increase in Critical Care services. Critical Care managers prefer to recruit experienced surgical RNs through internal advertising offering opportunities for career development the Surgical Directorate are unable to match, as shown in an advert (Figure 57) which was erected throughout the Clinical Division during a night shift.

Figure 57: Abridged version of ITU advert (Fieldwork document).

A distinct opportunity to discuss a Career within the new Centre

We are keen to hear from nurses of all grades and specialities who want to be part of the new ... centre

We welcome newly qualified or experienced nurses who ...

- Are keen to develop existing and new skills
- Have enthusiasm and commitment
- Are forward thinking and innovative

Benefits include ...

- Opportunity to be part of a friendly new team
- Flexible working patterns
- Exciting training opportunities tailored to individual needs
- Ongoing support from senior experienced staff
- Commitment to quality patient care

Senior Surgical RNs view critical care advertising as an attempt to make the 'grass look greener':

... there's lots of competition, it's a lot more attractive in ITU, HDU, Cancer Services, they offering study leave support. In surgery they do six months and then move on. It came to a head on Manet Ward last year. They all feel the grass is greener on the other side (Interview: Ward Manager Molly).

Those applying for these posts are Primary Nurses who have all the right credentials, their applications are always successful, leaving Ward Managers with the problem of how to maintain adequate Senior Nurse staffing. Although as a Night Sister who moved to critical care explained after three months of being in the new position:

I left because my working life was terrible and it's now the same ... I've just changed it for a different area (Fieldnotes: Night Sister Lily).

Even a Junior RN who moved specialism tells us she had been a student on the ward she moved to, but she soon regretted the move:

I moved about 5½ months [after getting the job in surgery] I decided I wanted a change, I wanted to try something different, I went to [a specialist medical ward] and it was always something I was interested in, and they made it sound great and said oh you can do this course and that course, and you can have whatever you want... when I got there it was basically you were thrown in at the deep end, you were expected to know a lot, there were lines and different products ... and you know it was all IVs and central lines and you know you're expected just to get on with it, and the drugs they give are so much higher doses than we normally give, doing the drugs, it took me ages, and I couldn't get used to it, I just couldn't get used to the pace it was totally different... so I phoned the Ward Manager and said have you got any jobs (Interview: Junior RN Pamela).

Concerns about the loss of Junior RNs in the directorate were raised by Renoir's Ward Manager at a Sisters' meeting, she informed colleagues two newly qualified RNs had resigned, a meeting attended by the Non Clinical Nurse Manager for the Division whose response was somewhat off-hand, **with a shrug of the shoulders and a comment they can be replaced (fieldnotes)*, a response which fuelled the Ward Managers to debate why so many keen, new RNs who had undertaken placements in the Directorate feel they cannot stay. The

remainder of the meeting was dominated by drafting a Retention Strategy in preparation for the twelve new RNs due to take up post.

For Ward Managers ensuring their wards are safely staffed is not just about retaining new RNs, the bigger challenge for them is management's cost containment and cost reduction agenda. The message from management is that costs need to be cut, and staffing is the area where this can be achieved, as a Ward Manager explains:

Being cost conscious is the fact every month you get spreadsheets back, we're looking, we're comparing last month's budget to what you've spent this month, with the money they give you annually ... but we don't have anything to do with the money we're actually given, ... it's all at the Business Plan side ... I only know from the spreadsheets. You could break it down because on the spreadsheets I get non-pay and pay, and out of that you've got all your various grades, costings per annum, with the on-costs obviously... but the frustration is I'm never in at the beginning to say where and how much we've got to spend and I have to move money around. I'm cost conscious but have no control ... if I save money, it's not ploughed back, because its all lumped together as non pay and whatever you may save on dressings you may spend on drugs. Whatever you make savings in the fact you've only got D grade vacancies, you spend it on agency - the one tends to outweigh the other - so at the end of the day - it's very rare that we come out on 31st March with a substantial saving it did happen to us 3 years ago but the saving was then offered over to another surgical ward to bale their overspend (Interview: Ward Manager Lucy).

The Ward Managers' major headache is their struggle to maintain what they feel is a 'safe' level of staffing for their wards, because they feel the nursing establishment is already at 'rock bottom' even before they have to manage staff sickness, and the changes to maternity leave entitlement.

In an effort to maintain ward staffing and to ensure the clinical developments required by management are implemented Senior Nurses have devised creative solutions to ensure recruitment and retention of new RNs, change shift patterns to reduce overlap, and allocate extra responsibilities to Senior RNs. All of which is being implemented alongside being forced to accept the Trust's recruitment of overseas nurses, and the continued use of an unpopular nursing agency.

'Growing your own' and retaining Juniors.

There is a 'Growing your own' philosophy throughout the Directorate, aimed at ensuring the Student Nurse has a good experience during placement, **it's about being good to the student nurses ... about making them want to come back (Fieldnotes Eloise on a night shift)*, a philosophy embedded throughout the Directorate:

You tend to identify whose gonna be a good nurse ... it shouldn't be like that but it is ... the student nurses, you know which ones want a job and which ones don't, and they'll say to you are there any jobs coming up when they're coming up to be qualified and you sort of know who's gonna apply for jobs... we've got a student on here at the moment and if I get this job she qualifies in April there's gonna be a slot coming up and she asked me the other day are there any jobs coming up and I said if I get this Associate job there'll be a vacancy (Interview: Junior RN Amanada promoted to Associate Nurse during fieldwork).

Student Nurse placements are important to the surgical nurses because they feel that providing a good experience aids future recruitment of new RN's, a philosophy experienced by Pamela which led her to want to come back to surgery:

in my training the majority of placements were surgery, not much medicine, it was the luck of the draw it could have been the other way round, could have been lots of medicine and not much surgery ... [this ward was] my first placement, then I came in the middle into the second year, then I chose it as my rostered service, so it was quite natural for me to want to come here, I liked it and felt supported (Interview: New RN Pamela).

Officially the Student Nurse is no longer an assistant labour force member because of his / her supernumery HE status, for some RN mentors this status creates a lot of issues, because surgical content in the RN curriculum is now minimal, and academic studies seem to take priority over clinical placements, leading to the general feeling new RNs on qualifying cannot pass a naso gastric tube or do the drugs.

The cultural practice of 'passing on expertise' from Senior RN to Junior RN relates specifically to standards Seniors expect, standards of surgical practice seen as essential for safe surgical patient care, standards which emanate from

the nursing 'era' the seniors trained in, and which they feel has been eroded in the student nurse training of today which lead the new RN to be vulnerable when choosing to enter a career in the surgical wards of today. Diminishing anatomy, physiology, disease-based knowledge, surgical skills and surgical ward placements in the Student Nurse curriculum of today are seen by the surgical nurses as a fundamental reason why the tools of the trade for safe practice in surgical wards are not present in newly employed RNs. Lucy a Ward Manager, tells of her concerns regarding the current Student Nurse curriculum

as a Surgical Nurse I can't understand how they [the fledglings] can nurse someone whose had an appendectomy, if they don't know where the appendix is, how do they know where it's gonna hurt, how can they possibly nurse someone when they don't know which bit they've taken away (Interview: Ward Manager Lucy).

Although as Primary Nurse Beth points out you cannot blame the situation wholly on the 'Project 2000' initiative as she undertook the first Project 2000 curriculum, her concern being how the curriculum has changed in recent years, leading juniors to experience problems on Registration:

... during our training we had longer periods on the ward, we had a taster of surgery in our first year and then we went back to surgery at the end of our last year, by then we had developed our knowledge and skills for our assessment ... managing a whole bay for a whole shift, on reflection to what occurs now that was an easy assessment because we were often left in a bay on our own, on a shift anyway and we got on with it ... these days the newly qualified nurses have never even put a naso-gastric tube down in their life (Interview: Primary Nurse Beth).

The need to have a more formal approach to support the newly appointed / fledgling RN recruits, is as a direct result of 'a lesson learnt' from the high attrition from the previous recruits, which the Senior Nurses put down to 'too much, too soon', the 'culture shock' of transition from a student to an RN as Beth explains:

... I think now it's a hell of a culture shock for them from being a student one day and then having to do it for themselves ... because recruitment and retention, and burnout and staff getting upset you try to protect them and that is why you double check, because also you spot something they haven't done, you go and say look this is ... this is something they've missed to try and teach them so they won't do it again, instead of the problem becoming a

big issue, before you know it you've got a critical incident on your hands ... that is the reason we tend to double check, a lot of the time, it's also about the complaints culture, averting complaints, averting risk (Interview: Primary Nurse Beth).

To avoid the 'wasted time' of recruiting and training more juniors only for them to leave, the Seniors put in systems to support the twelve fledglings in the form of a retention strategy shown in Appendix 33, comprising an induction programme and a surgical nurse competency development package, outlined in Appendix 34, to ensure new RNs develop skills to practice as capable surgical nurses, which Senior RNs deemed essential for safe practice in their new role.

Thus the fledglings are embarked upon an 18 month rotational programme, the benefits of which are that the junior RNs on its completion will be ready to apply for an Associate Nurse post. To the Directorate the benefit was described as:

Ensuring uniformity of skills and knowledge therefore ensuring a quality patient service. Professionally developed junior Staff Nurses progressing after 18 months to Senior Staff Nurse therefore providing in-house Staff Nurses, a grade increasingly difficult to recruit (fieldwork document)⁹⁹.

After the retention strategy was finalized by the Senior RNs, a key to operationalising this was creation of a pilot post for one Primary Nurse three days a week, the Clinical Skills Facilitator (CSF). The Modern Matron then approached management for the CSF role to be made official, a role already established in the Critical Care Directorate, a proposal fraught with opposition from the Divisional Nurse Manager, who is also Divisional Nurse Manager for critical care, who stated **it's un-necessary (fieldnotes)*. Against the backdrop of management opposition Ward Managers decide to 'go it alone', freeing up a Primary Nurse for one week to prepare an induction and training programme for the new recruits, making this post a two day per week secondment from a full-

⁹⁹ Simultaneously with development of the surgical competency programme for new RNs concerns were being addressed at the Health Authority, the project co-ordinator presented at the Ward managers meeting a regional competency package. The Senior Nurses' view being their own was more specific to the RN's role in surgical wards (fieldnotes).

time Primary Nurse post, although an exciting development for the Directorate, from the perspective of the Ward Manager releasing the Primary Nurse she is now 'carrying a ghost':

she's got a dual role at this moment in time she's got 60/40, a dual role as clinical nurse and teaching, the CSF role it's been excellent, done on the back of retention issues, the Juniors that she's nurtured since March are happy, they're content, they feel fulfilled and they're now confident now I'm not saying that this didn't happen before but the fact was it was very ad-hoc, hit and miss, depends who was on with them, they didn't have someone they could actually say - well I've got a problem with ... with this particular group we've been exceptionally lucky, on the back of that role obviously [the CSF] has made a massive impact ... I had to make a sacrifice in losing Louise for 2 days a week but the benefits are there ... I pay for the role ... it is being generous ... but as I say it was either half of [the CSF] or none, because she would have left... it's a ghost post (Interview: Ward Manager Lucy).

The Senior Sisters took matters into their own hands, making time for the Primary Nurse to be released from her ward role, ensuring no additional financial costs on the nursing budget, a current non-clinical management objective.

Dual Roles (the bifurcated RN).

As seen from implementing the CSF role, this was created from an existing Primary Nurse post, an approach to get through the work and meet demands without additional resources is to allocate to experienced RNs additional duties. A case in point was the Trust requirement to introduce the Essence of Care, each ward had to nominate a Senior RN to drive this through the ward and report to management what they had done. This bolt on role for Senior RNs was the Divisional management team preferred model for addressing government and Trust initiatives, including implementation of the Trust risk management strategy and collecting and processing audit data on surgical targets, major management initiatives achieved with no increase in staffing, resulting in Senior Nurses being like sponges, soaking up government and management agendas.

A Primary Nurse currently in a dual role as a Clinical Nurse Specialist (CNS) in a GI specialist service tells me the role evolved because workload in this service had risen tremendously. The dual role she tells me leaves the ward short staffed ... she would like the role permanently but discloses why this will not happen:

You are contracted to anywhere in the surgical unit ... so management can do anything with you ... I see a big future for this [CNS] role but I've been told its not funded ... but at the end of the day I'm acting up at the moment ... I'm actually earning an extra few pounds a month, the problem is they won't top it up to full-time because the unit is overspent... but they are not looking at it laterally, they're not looking at it how much money they're gonna lose when they lose so many staff nurses because they don't feel supported ... and if you lose staff, invariably you're going to have to employ agency staff for the interim ... they're not looking at the long term future at all. Whilst I'm doing this 2 day role I'm still practising on the ward, doing 3 days a week doing that role and 2 days working here ... there's a lot of those roles around the Directorate its getting us on the cheap, to be honest I felt I couldn't do it properly, on a part time basis... (Interview: Primary Nurse Denise).

Use of Agency Staff.

There is a heavy reliance on agency staff on surgical wards because of the freeze on employing permanent staff. On Renoir in particular they have an agency nurse on nearly every shift, which creates problems for the permanent staff particularly because of the variable quality of staff sent from the agency, many of whom are employed at the assistant grade and are current student nurses, and a cause for concern

students used to only be allowed to do agency work in their third year of training, but as a Primary Nurse pointed out it appears you can be on the agency now after signing up to [nurse] training (fieldnotes).

The Trust contracts with two privately run nurse agencies, when the contract for one came up for renewal Ward Managers expressed concern as to the quality and reliability of the agency and were very unhappy when the Trust renewed their contract, without consultation at operational level. The agency nurse situation came to a head at the sisters' monthly meeting, where one sister had placed the issue on the agenda; it came to her turn in the meeting and she told

the Chair the 'James' agency were still sending unsuitable staff, and this was noted. The problems agency nurses bring to the wards are numerous:

I've had a lot of agency, and I ask for regulars and you get somebody you don't know from before, it is difficult if you don't know them from before ... it is difficult being an agency nurse working round different places ... sometimes it's been better just to do it yourself ... sometimes it's just better not to have anybody, given what they've sent you (Interview: Ward Manager Molly).

An example of this occurred on a night shift, an RN told me her concern about the fact nobody is sent on a regular basis, even when the person at the end of the phone knows you; one incident I was party to explains this:

... an agency nurse on a block booking for three night shifts was here last week, she hadn't done much all night [on her second shift] then her mobile phone went off so she went to the locker room, answered the call and then just left the ward ... it was 6 in the morning, she wasn't due to finish till 7.30 and we were really busy (fieldnotes).

Amanda revealed the true extent of problems regular RNs face when employing agency staff, when she indicated it is sometimes better to 'do it yourself':

a lot of agency nurses won't do things ... what I mean, you'll get an agency nurse that wouldn't take a drain out, you'd expect them to do it, but sometimes when you get one employed at a junior grade they won't do the drugs... I respect them when they say I won't do IV's, that's fair enough, they haven't been trained in this Trust, although we haven't got any protocols saying you need to do our course here ... if I went to another hospital I wouldn't do IV's, but they won't do oral drugs (Interview: Associate Nurse Amanada).

On an odd occasion there would be positive comments about agency staff as Degas Ward Manager indicated **you can build a rapport and they'll return (fieldnotes)*. Although the overall opinion seems to be management want ward staff to cut agency costs, but Senior RNs need them to fill the manpower gaps:

staffing wise, the cost of agency staff as far as I'm concerned isn't an issue the wards got to be covered at the end of the day ... I've had times when I haven't been able to get hold of management anyway ... and there's a crisis in staffing and by the time they get back to me it's too late, I've had to stop on the whole day ... it's safety, it's your professional judgement (Interview: Primary Nurse Beth).

Overseas Nurse recruitment.

Recruiting overseas nurses was sold to the RNs as the Trust's approach to fill supposed vacancies, a decision made by management with no consultation with clinical staff. The overseas recruits in their own country are RNs but once in the UK are required to undertake an adaptation programme prior to entering the NMC Register, resulting in the Trust having to develop a hospital-wide competence programme, co-ordinated by a lead nurse with each recruit allocated to a Primary or Associate Nurse. The journey to registration for the overseas nurse requires teaching and assessing by the Surgical Nurse over a six to nine month period, until the recruit can demonstrate the same level of skill in the statutory competencies for admission to the professional register as home trained RNs.

Once Senior RNs completed their support of the first cohort of Overseas Nurses in the Surgical Directorate they raised concerns there were no vacancies on the wards, telling management home-trained RNs were asking about vacancies. These concerns fell on deaf ears because the second cohort were en route. Ward Manager Lucy on discussing current recruitment expressed her concerns:

I've got two [overseas nurses] which I've taken on, but I do feel certainly we were hoodwinked into taking them, we had junior grade vacancies but I'd actually got a list of 2 or 3 students that want to come back, they were students here... they're [the overseas recruits] on our budget now ... it wasn't made clear these girls were going to take up my vacancies ... they just have to slot into vacancies ... as far as I'm concerned it could be an issue with equal opportunities, in the fact they haven't gone through interview, they haven't been short-listed, they haven't gone through any of the rigmarole the juniors, the new girls go through and yet they're just given a job on completing 6 months (Interview: Ward Manager Lucy).

Another Ward Manager described her position as lacking control over overseas nurse recruitment and the additional problems this causes:

I've inherited [an overseas nurse] from another ward ... she's only just started ... she's a lovely girl but communication is difficult ... and we've had a problem with a post-op patient, looking after a post-op patient and she

hadn't done any drugs ... I spoke with the co-ordinator of the overseas nurses ... told her she's got a problem ... she should be able to do them ... she's coming today to see her, the girl and the staff nurse who's allocated as her preceptor ... she has been six months on another ward ... her problems are communication (Interview: Ward Manager Molly).

A further Ward Manager explained she had been informed overseas recruits were free regarding her nursing establishment budget throughout their period of adaptation but on receiving the monthly staff spreadsheet found them employed into RN vacancies at an auxiliary grade; she questioned this with the Business Manager following which she was **called to the office to discuss this (fieldnotes)*, the outcome of which she declined to discuss.

A Primary Nurse as a result of her own ward experiences of working with Overseas recruits gave an example of the added responsibilities she has to manage when mentoring to the adaptation programme:

I've got an [overseas] girl and one of the things you have to sign off to say is their communication ... that they understand, they can speak, they can carry out duties and understand those duties 100% of the time ... and that's one of the things that you have to sign for [for our professional body] there's about 5 points you have to sign for and I took it up with Mary [the assistant chief nurse] ... I said I'm not happy with this particular one ... my nurse ... I know when she doesn't understand me ... she's a very facial person, I know when she doesn't understand and there are times now when I'm not on duty and people, other people who haven't got the patience and time that I might have, because I know her ... that I just shout things at her and she won't know ... she won't pick it up ... and they won't go back to find out (Interview: Primary Nurse Hanna).

The conditions of Surgical Nurse production.

The general conditions of production for RNs in the Directorate are in some ways 'Dickensian', a term I hope creates an impression of what the labour force have to cope with in the course of their work; a Senior Nurse sums up what she has to put up with:

we have no rest room ... as for lunch and breaks, staff are entitled to these they're all entitled to a break, they can take them but it's a problem, I make sure student and agency take them on the main wards there are problems from my own experience to work from straight from the beginning till well over your time without a break is not uncommon ... or having a break but

not getting it because you've been disturbed because something's happened on the ward, there's a relative, or a consultant turns up, and I'm guilty of it ... because as a junior member and there's a visiting consultant on the ward, whose come to see a patient and I need my presence to be known, its not because of the - Sisters syndrome or Staff Nurse syndrome, its because I'm aware of where they're coming from, what they're coming for and I probably have all the knowledge for that consultant about that patient ... more so than the juniors (Interview: Ward Manger Beth).

During a Sisters' meeting an agenda item was stolen staff property and the Matron read from a new Trust policy on this, but those present raised more fundamental issues related to there being insufficient lockers for staff, books going missing from their wards, and more recently staffs' personal items being reported stolen.

The NNPs working conditions are the most appalling because they have no 'space' they can call their own, yet they are expected to produce reports and reviews for management. Although there is one tiny clinical room behind a particular ward which they have tried to have designated their HQ, because it belongs to a ward and is used as the ward's rest room NNPs have resorted to being 'portable', carrying their wares in duffle type bags. An RN confirms the working conditions she has to endure are appalling as she reels off:

... theres no time in lieu book so when I work over I can't prove I am owed tme, I often have to come in for meetings and mandatory training, we're entitled to have a break but there's nowhere to go (Fieldnotes).

Poor working conditions extend to patient care, revealed as work commenced on the Essence of Care benchmarks on one ward where the ward team identified there was no private area for giving bad news, which related to the privacy and dignity standard:

we actually reported back, we did this as a ward and we identified patients had no sitting area, a patient sitting area, where we are sitting, it's dual purpose, because if we send a message out this is a nurses' sitting room, we've lost a bed but we haven't lost a bed because there wasn't a bed in here, but there is a facility to put a bed in, whereas if it's classed as a quiet area the breaking bad news room, the confidence type place then it's a patients' area so that's why its going to be a quiet room, its gonna be called after a patient's name because he put the money in from a donation, it'll be called this patient's name. I bet you my bottom dollar it'll be removed for

capacity management, because last year they tried to get us to put a bed in here and I refused point blank, last year it was used as a storage area (Interview: Ward Manager Lucy).

What is of great concern to the surgical nurses is the lack of **the tools of the trade*, as one RN put it, which comes in many shapes and forms, from having to beg HDU staff to let them borrow a patient hoist, to sending the Nursing Auxiliary to 'other' wards because there is no linen. Most concerning is the lack of basic patient equipment in the form of electronic pumps, because those in use on the wards are needed in the operating theatre for new surgical patients; this requires patients to be rapidly reviewed on the ward, converting medication to an injection or table, releasing a pump for a new patient.

The overall work situation for the surgical nurses is all about 'getting through the work', the by-product is 'being stressed', a situation which came to light early into fieldwork, as a result of eavesdropping on RNs discussing **I can't cope*, and noticing RNs sitting at the Nursing station with their heads in their hands;, on occasions I found RNs in tears, as a fieldwork extract illustrates:

Tonight I found a newly qualified Staff Nurse in tears, when I come on the night shift. Two hours later she was still there (11pm) doing her documentation, I offered to help, she said 'I can't cope'. On this same shift the daytime Primary Nurse was there after six hours of overtime, she saw the junior in tears and said 'I didn't do enough to support her' (Fieldnotes).

Today I went on duty for an afternoon shift, as I walked into the ward the Ward Manager wanted a private chat, she was feeling nothing is wrong with the ward or herself, but the system is failing her. She told me she had decided long and hard to bypass her manager, to go to the top nurse to ask for money to retain X - but it fell on deaf ears. She said 'I'm really fed up', I feel bad about bypassing my manager but she can't do anything, she's 'locked in' (Fieldnotes).

RNs' stress also evolves from their feeling they have little or no support from management, as Kathleen explains after returning from undergoing a hysterectomy

I had no support when I returned to the ward, I feel I haven't done a good job introducing policies, I've had no training, no time for me to understand the policies, and no one to go to, no one to discuss issues with (Interview: Ward Manager Kathleen).

Lack of support for Senior Clinical Nurses was prevalent throughout the Directorate:

I think management listen, but they don't do anything about it ... they sweep it under the carpet, I went to [a senior nurse] cause I was really despondent with the ward, I felt standards were getting terrible, everybody was just coming to work doing their job and going home, couldn't think further than the end of the day and I poured my heart out to her and the next day I was called to the office and told I hear you're not happy ...

I'm always in charge of the ward, I find that quite stressful, being in charge and heading a bay and supervising, it's not that I can't cope or there's too much being put on me Its because I'm working to full capacity and if I'm given just one more thing - a relative, a complaint, a blip and I'm thrown completely, or a patient goes off ... it takes up all my time. And then like the other girls are so wrapped up in their stuff I can go without seeing my patients for an hour or so, and you go in and there's been no observations done ... and no fluid balance charts ... (Interview: Primary Nurse Tina).

During an ethnographic interview with Kathleen the topic got round to her colleagues feeling they felt stressed ... her response was:

... it's really comforting to think there are other people [who experience stress]. You feel sometimes I've done a good job today, other days you feel you haven't ... you get that less as you get more senior so you start to question your ability ... cause there's so many things coming at you some days you're almost overwhelmed.

I go home some nights and feel anxious, or concerned, and my staff do ... there's no one we can go and talk to in the Directorate, you see the problem [...] you should be able to go to your colleagues and meet together ... there's nobody at all, no, there are times when you feel very very frightened, it's a big con isn't it, as you get more experienced you, cause at first you're looking to all the dangers and what might happen and all those things have to be put to the back and most times you say ... but other people do think very differently, they think you, one of my staff said to me the other day - she said, you never panic about anything do you ... I wish she knew what was going on inside of me ... You can't afford to give that impression though (Interview: Ward Manager Kathleen).

Because Senior Nurses are experiencing the pressure themselves, they are appreciative of pressures on juniors, and respond by being protective:

I was stressed a lot when I was on the other ward, and the fact I now wear a mouth guard, because I've ruined my teeth - grinding my teeth ... because that's how I coped with it, I'd go to bed at night grinding my teeth

and I'd wake up in the morning with aching pains, jaw pains and my jaw would be clenched, I got out of the other ward because of that stress ... I'm used to it now, that's why I'm so protective of the others, because I've learned it's been enough to cope with, with things when they've been put on your plate over the years, the extra bits, the more paperwork eh - ? if they're able to be out by the next day it means the ward's full of heavy, ill, dependent patients its a lot to cope with that workload so get on with it ... I've learnt to cope with anything that's put on my plate over the years and it was a struggle and I think that's why people don't want a Ward Manager grade because there's so much on their plate (Interview: Ward Manager Beth).

A final area of concern regarding conditions under which RNs work is the recent introduction of restrictions on their Human capital expansion, and a real concern, given the fact this Directorate has a long history of supporting staff to undertake post-registration clinical courses. Current management philosophy is **there's no or little study leave for post registration courses, except for mentorship*. RNs in the Surgical Directorate have to wait to see what funding arrangements are in place to pay course fees because the study leave budget has been drastically reduced. If the ward decides to send an RN on a course, policy states **there's no agency nurse to replace study leave (fieldwork document)*, leading staff to pursue courses in their own time and some are even dropping their hours to achieve their degree:

I'm doing my degree fairly early on because I heard on the grapevine that in time to come for promotion you're gonna need it, if you wanna get your Sister's post and things like that you're gonna need it, I've dropped my hours, it's a shock, but OK (Interview: Associate Nurse Amanada).

A Ward Manager discussed a letter from management regarding study leave ...

I've got to cover the ward, now I can't have agency to cover the study leave and that particular person we're on about, I've had to fight, I've had to fight for, to get the two days [study leave a month] because she'd already started the course, the degree. I just find it difficult when I know I've got to have a study day per month till March next year ... because of this thing [pointing to the letter from management] I can't give it to them and I do try, I've been trying to book a lot of single days, hours for people because why should they do it in their own time. It's also a retention issue ... it's a big issue I think at the moment. When I did my BN I had it paid for and I did like half the shift, so half time. and a lot of the courses people pick to do, are in your own time (Interview: Ward Manager Molly).

Despite external, university-based RN education being restricted for the RN, the amount and speed at which new internal training within the division developed was phenomenal. Most of this was provided by critical care Directorate staff, ranging from one to five day programmes aimed at upskilling RNs in venepuncture, cannulation and IV drug administration and also aimed at skilling staff to avoid undetected patient deterioration in the form of providing the one day ALERT course and attendance at the five day in house High Dependency (HD) programme, the content of which is outlined in Figure 58.

Figure 58: Critical Care in house five day HD programme (Fieldwork document).

- Oxygen administration and humidification
- Chest drains
- Outreach service
- Tracheostomies
- Role of physiotherapy, positioning and suctioning
- Respiratory support - CPAP, NIPPY
- Basic airway management and respiratory adjuncts
- Emergency intubation
- Infection control
- Basic life support (theory of ALS)
- Cardiac arrest scenarios
- Cardiac monitoring and lead placement
- Basic cardiac rhythm interpretation
- 12 lead ECG
- Insertion and management of CVP lines
- Pressure transducing calibration and sampling
- Arterial blood gas interpretation
- Renal failure and renal therapies
- Fluid resuscitation
- Diabetes
- Shock (cardiac, anaphylactic, hypovolaemic, septic)
- Pain assessment, epidural, PCA
- Nutritional assessment, TPN and enteral feeding.

Chapter 6: RN role development, role expansion and role extension in the surgical milieu.

Having entered into this research as a result of NHS RNs alerting me to the difficulties they were experiencing developing, expanding and extending their role in the surgical milieu, I admit I was unsure of what the research would reveal. Although at the time I had an expectation I would capture RNs taking on a range of new roles, acquiring new skills, and in government speak would be 'working in new ways', because RNs would be taking this for granted I could capture and report their day to day work and the context in which it was occurring. Fifteen months of data collection and inductive analysis, followed by a period of interpretation, culminated in the realization there is no overarching approach to explain the many facets of the RN role in relation to its development, expansion and extension. In relation to the surgical RN role development, role expansion and role extension, the findings are now presented from several perspectives.

From Junior to Senior [Surgical] RN.

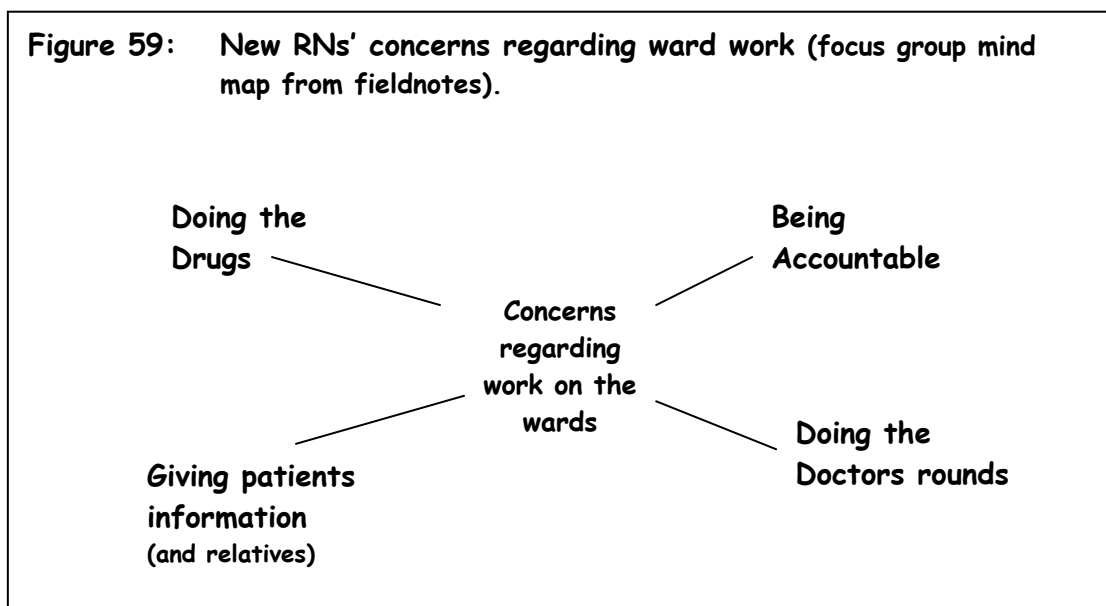
The journey from newly qualified RN following being appointed to a vacant position in the surgical wards is a journey embarked on by the fledgling¹⁰⁰ RN comprising a mixture of natural role development as a result of the passage of time, role expansion as the RN becomes competent in applying surgical nursing skills for their allocated patients, and role extension up-skilling through in-house provided training.

Twelve home trained RNs were appointed on commencing the study, an unusually large number due to the high attrition from the previous cohort of recruits. For the fledglings, although their training is now over, they are initially in limbo in

¹⁰⁰ **Fledgling** is denoted to mean 'inexperienced' as an RN, following completion of their 3 year RN training programme.

this new role as they are neither Student Nurse or RN until their PIN¹⁰¹ arrives. Their journey to Registration begins with a set of 'symbols' differentiating them from regular RNs. These symbols comprise an ID badge labelling them 'Junior' Staff Nurse, a white dress and pale blue belt for females and a white tunic and pale blue epaulets for males, symbols which continue to be worn until **their number comes through (fieldnotes)*.

At the newly appointed RNs' induction week their concerns about being an RN in their first post were explored and mapped, shown in Figure 59.



The foremost concern was their role in the administration of drugs, **I'm concerned about administering the pills, not so worried regarding injections, but not IV's, I've not done fluids via IV at all (focus group fieldnotes)*, in fact a lot of time was spent discussing these concerns and reassuring fledglings they would be supported to acquire these skills. A further concern related to giving patients information:

Giving Patients information about surgery, the worry is will we get it right ... is our knowledge right (focus group fieldnotes)

¹⁰¹ PIN: Professional Identification Number.

Although raised by only one of the new RNs, this led to quite a heated debate about how they felt they were in for a steep learning curve with relatives:

it's gonna be tough ... but I've been on the ward as a student and they're very helpful, I've been with the Primary Nurse with relatives, I'll just have to learn how to deal with them (focus group fieldnotes)

Concerns regarding information-giving to patients and relatives were closely linked to their asking questions about when they would be expected to liaise with doctors and be part of the consultants' ward round.

Senior Nurses who were involved in interviewing the prospective candidates for the Junior RN vacancies indicated there is a 'continuum of capability' from one fledgling to another; a continuum which is vast, as Grace explains:

I think there's a greater variation in their skills, some of them are as good as we were, but others are nowhere near, I just think the gap is wider now, the good and the not so good... (Interview: Primary Nurse Grace).

and a view shared by the Ward Managers, despite their rigorous interviewing of new recruits:

There's not much to choose from at interview, our interview process is very rigorous. You can't tell what grades they got when training, they could have failed lots of things, it's not like a degree where you've got a final grade It's only after they start you find out what they're really like, unless the girls tell us because they've been a student on the wards ... (Interview: Ward manager).

The fledgling's PIN eventually arrives in the morning post, marking their official status as an RN, and a day to celebrate. Some of the fledglings are excited and share their news with team members, their pride in being **from today I'm a proper nurse (fieldnotes)*. But others choose to keep this landmark private, described by Ward Managers as a coping mechanism. Ward Managers overcome this by casually enquiring **have you received your PIN (fieldnotes)*. With the PIN comes the accountability and responsibility the new RN has signed up for, and so the right of passage is operationalized in the form of a regular RN uniform and their true journey commences because up to this point:

... they can't be left to do the drugs on their own, until they have passed their drugs (fieldwork discussion with CSF).

The pathway to become a capable RN is a complex, convoluted journey fraught with an urgency to get the **junior up to speed*, to be in charge of a surgical ward, due to the ever-diminishing number of senior RNs as a result of management's sequential erosion of Seniors in an effort to reduce nursing labour costs. The journey comprises learning on the job, internal training and accessing clinical courses in the local university, but the latter are becoming difficult to access, so what is increasingly occurring in the Directorate is the 'in at the deep end' model.

Although the retention strategy is in place to train up the new RNs, the reality shock of being an RN kicks in sooner than I expected; having bumped into one new RN on her third shift on the wards she told me *'I haven't slept since Monday, I'm so tired'* (fieldnotes). Ethan illustrates his experience of the difference in being a student nurse to now being an RN:

It was quite daunting, it was a very busy time for the ward anyway and we were quite short staffed and I was really re-learning everything to be honest ... it's different when you're a student to now, the emphasis is more on you, I think the support on this ward has been great and I really mean that ... I've had good support ... you're accountable, you have your bay and even though you do get good support, it's you that has to remember all the little things that maybe as a student you don't have to remember, like discharges, you have to cover that fully, you can't leave that for the qualified to do the district nurse referral or the OT referral, or check his tablets, just little things like that, it all adds up ... and also just getting a picture how this ward is run, you know you see the consultants, and you see there's various doctors underneath them, doctors who've been referred to them, you see physios coming. OT's you know... (Interview: New RN Ethan).

It soon becomes evident the fledglings are not coping as well as anticipated, since they can be found in backstage areas of the ward two hours after the shift has finished, discussing issues they are worried about.

Senior Nurses hold views about today's new recruits, which came to light through statements like **they're as green as grass'*, **they're just not ready from school* (fieldnotes), even though the majority of the new recruits having undergone student placements and therefore have been part of the

Directorate's 'growing your own' culture. Senior Nurses feel the new RNs need a lot of support and supervision:

they're just not ready from school now to go straight into a Staff Nurse role, we were more prepared in my day, now they're just beginning to learn the ropes when they start, they can't do the basics in a bay ... it's why/how the essence of care came about because they're not up to scratch on the basics ... things like bed bathing, oral hygiene, diet and nutrition, so you do really have to start from scratch with them ... the drugs is a problem they don't have the exposure, on doing drug rounds in their student training, because people haven't got time to... because it is obviously slower having students with you, so they don't get the exposure, they're as green as grass (Interview: Primary Nurse Faith).

Some go further, suggesting **the juniors are not qualified to care for a bay of patients ... *their white belt 'it's security', *the Juniors rely on technology, *it takes 2-3 years to train them up (fieldnotes)*. Senior Nurse statements verified through describing their experiences of having to draw diagrams for juniors on what they viewed **simple surgical concepts*, they [senior nurses] were taught in their training; an example is provided by a GI Nurse:

... the upper GI nurse is trying to explain why the patient is vomiting following bowel surgery, she was explaining how the stomach fills up with fluid, they get small and regular vomits and their SATS are down because he can't expand his lungs, she draws a simple diagram (fieldnotes).

On a night shift I was recognized by a new RN as the person who gave a lecture about amputation; she then asked me about the lady with the gall bladder problem:

... the nurse was having difficulties understanding what was happening with the patient and she couldn't make sense of the medical notes, I went to the whiteboard and quickly drew her a diagram of the gall bladder and gall stones, how a small stone can block the bile duct and hence the patient is jaundiced she was so pleased and she was a third year, she said I wish they taught us more of this in school (fieldnotes).

This line of enquiry was developed with Ethan, a new RN, through asking him about his experiences of surgery during his training:

I did critical care [as my option module at the end of training] I didn't have much surgical input and to be honest the sort of physiological side of it I've been learning since I qualified, I mean learning it myself, reading, after three or four hernia operations you know what to look for, you know ... I mean the training's OK, but not much surgery ... (Interview: New RN Ethan).

On night duty a junior was caring for a man with a swollen penis and was heard making a call to the NNP about the swelling, because he hadn't any idea why this might be occurring and what to look for:

... the NNP arrived on the ward and started asked the new RN simple questions like has the man passed urine, does he have a temperature, but he hadn't thought about these and found difficulty responding, the NNP explained swelling on the outside can also swell on the inside and therefore the most important observation is urine output ... they both then went off to see the patient ... (fieldnotes Night Shift on Manet).

The NNP then tells me this was a simple condition she learnt in her training and indicated she could not understand why they do not know these basic things. These experiences led me to ask the fledglings for their nurse training transcripts to explore the clinical placements they had experienced during their three year programme, shown in Appendix 35, from which the amount of surgical experience was extremely limited, shown in Table 21, ranging between 15 and 20 weeks, with four of the six new RNs having also experienced an operating theatre.

Table 21: Surgical Clinical Placements during the new RNs' Dip HE / RN training.

| Student | Common foundation (Number of days) | | Adult Branch (Number of days) | | Total number of Days | | Total Weeks ¹⁰² (+) ¹⁰³ |
|----------|---------------------------------------|-----------------------|----------------------------------|----------------------|---------------------------------|----------------------|---|
| | General & special surgery | Operating theatre. | General & special surgery | Operating theatre | General & special surgery | Operating theatre | |
| A | 31 | | 65 | | 91 | | 18.2 |
| B | 45 | | 34 | (35) | 79 | (35) | 15.8 (+7) |
| C | 32 | (14) | 68 | | 100 | (14) | 20.0 (+2.8) |
| D | 27 | | 49 | (35) | 76 | (35) | 15.2 (+7) |
| E | 31 | | 58 | 35 | 89 | (35) | 17.8 (+7) |
| F | | | 92 | | 92 | | 18.4 |

¹⁰² A week is calculated as 5 working days.

¹⁰³ (+) the number in brackets indicates the number of weeks spent in an operating theatre placement.

Fledgling development is all about getting them **up to speed*, to be able to provide the total range of care for their bay of six patients, and a patient in their side ward, a total of seven patients in the Primary Nurse system. Initially they focus on **getting through the tasks*, rather than delivering holistic care, as Eloise explains:

They [the juniors] have the handover and they write tasks down, rather than diagnosis and social problems, they're bothered about getting through the work, rather than what's actually happening to the patient ... as they get more experienced, those tasks that seemed really important are now tasks they do without even thinking and you are way above that level now you're thinking wider, you're thinking well if that patient down there does this and what can I do there and you're actually thinking of 27 patients, not just your 7 ... immediately post qualifying it's all about managing a bay of patients, managing themselves, managing a bay, time management, dealing with senior staff, with consultants, they're very frightened of consultants, to the point of like hiding behind the curtain and won't come out and learning to be an advocate for your patients is one of them, not accepting that the consultants, doctors, house officers are right, you always question what they are doing, prescriptions, and you know you've seen it... (Interview: Associate Nurse Eloise).

A particular landmark for the Juniors is being able to organize and prioritise care:

When I first qualified I'd be wash, wash, wash, wash - wash, wash, wash, do my drugs, wash, wash, wash, but now I find that - oh - I'll take that drain out before I get you out of bed and then I'll do everything all at once, and you can manage yourself more and you can think, think more logically than when you first qualified and I think well why I am waiting to do that, I'll go and do this, and when I'm going to do this I'll do that. I think while the student's doing that I'll go and do the observations and you just flit around and today the only thing I've got left to do is the bloods and go and get a lady back into bed, a lady who wants to get back into bed..... but she needs to sit out... its in her best interests I go past her and say - hello and wave then a bit later I'll get her back in bed but you could think I'm lazy, not putting her back in bed but she's got a tracheostomy and a bad chest and I just want her to sit out a bit longer (Interview: Newly appointed Associate Nurse Amanda).

On an operating theatre day, the need for the Junior to be organized is vital, because surgical patients require additional care in the form of pre-operative preparation, and immediate post-operative care. A profile of one new RN's seven patients on an operating day shift [7.30am to 3pm] was:

1) a first day post operative open cholecystectomy, with a drip and a drain, 2) a slightly confused lady for discharge via ambulance mid morning, 3) a lady due to undergo emergency bowel surgery on the morning list who was admitted in the night, 4 & 5) two patients for elective major surgery, 6 & 7) two older ladies who had major surgery last week and whose recovery is quite slow ... of the seven patients, two are diabetic (fieldnotes).

For some fledglings the first few months of employment on an acute surgical ward is 'too much too soon', and the grass looks greener elsewhere, as Pamela explained earlier (page 196).

A landmark in role development for the new RN is drug administration, not only the tablets but the intravenous fluids, injections and the management of medications delivered through electronic pumps, which are prevalent in the surgical wards. Becoming competent in IV drug administration is an absolute priority for Juniors, not just because it relieves Senior RNs of this task but because it is essential for the Ward Manager so the Junior can be left in charge of the ward¹⁰⁴, and to fulfil this role IV drug administration is an essential skill, it is a traditional role expansion area for RNs following registration. I pursued the issue of drug knowledge and skill in the curriculum with Pamela, a fledgling RN, as a result of seeing the urgency of 'getting the juniors up to speed with drug administration,' which was included in the surgical competency development programme:

we had the drugs assessment but you don't really go through drugs, it's just drugs calculations, pick one drug ... and I think I picked Penicillin ... and that's it ... there was nothing... you think how useful it would be to have a module on [pharmacology] just side effects alone, you know... anaphylaxis and stuff like that... and giving IVs (...) about 3 months after I qualified I was giving IV's I worked with others, mainly E grades and then the clinical skills facilitator said when you've done it 5 or 6 times she saw me do it and asked me some questions about giving them ... I haven't been on the study day, the Clinical Skills Facilitator said there's one coming up in January so hopefully (Interview: Fledgling Pamela).

¹⁰⁴ Because the new recruits are not competent in this area of practice on registration, part of the retention strategy is dedicated to drug administration competency outlined in Appendix 34,

There is some confusion regarding how juniors acquire the skill. One was giving IVs after just three months, having learnt this on the ward with the skills facilitator, but was going to do the theory day later on. I asked Ethan, a recently appointed staff nurse, about his experience of learning to give IV drugs a few months after being appointed:

I'm doing IV drugs now, im giving them as a bolus, I was assessed on them, I was shown by the clinical skills facilitator, sat down with her, with a patient ... I haven't done a study day, and that is something I have to question, I know there's some education that's needed, I'm feeling confident about IV's (Interview New RN: Ethan).

IV drugs are increasingly prescribed; on one night shift alone there were 26 separate IV drugs to administer at 10pm and the fledglings are keen to contribute to the rising number of intra-venous administered drugs, particularly when caring for a bay of patients they call their own. What is worrying however is the fact some are developing the skills of IV drug administration before having been deemed competent to perform a drug round.

The overall aim of 'training up' the fledgling is for them to be capable of delivering total care for their seven patients in the Primary Nursing system. Becoming labelled as a capable RN in the surgical ward means demonstrating they can cope with what comes through the door, whether this be a planned or emergency surgical admission, or a medical or trauma orthopaedic patient due to bed shortages around the hospital. Coping and capability includes dealing with patients' relatives, and other 'visitors' wishing to see their patients, and even police personnel who are frequently found handcuffed to recovering surgical patients. This demonstration of capability in coping with the demands of leading a Primary Nursing team is initially done under the supervision of a more senior Primary Nursing team member but this soon extends to shifts where they are on their own.

Soon after managing their own Primary Nursing group of patients, and usually on an evening shift, the fledglings role expands into having to cope with overseeing

care in the adjacent Primary Nursing team, because it is staffed by an agency employed student nurse moonlighting as a Nursing Auxiliary. Their role expands into supervising and advising on care for an additional seven patients, a supervisory role which also occurs during the skeleton staffed night shift, when the Senior Nurse goes on her one hour break; the fledgling's remit can extend from seven to fourteen patients, or even the whole ward of 28 patients dependent on the grades of the 'others' on the night shift. Pamela explains what her first six months has been like following registration:

I did feel there wasn't much support, and we were short staffed and you'd find at times you'd have two bays and there would be no senior nurse at times, or there would be an agency B grade in the next bay, and you'd be overseeing them ... it was so hard they were coming to you for a lot of the stuff you know, on my first day there was a first year student in there and she was asking me everything under the sun and it was my first day, I said ... I don't need this ... things are a little bit better now staffing is better it was just so difficult, I mean there could be, like me newly qualified, somebody else newly qualified 6 months and two agency B grades or an agency D and a B and I've only been qualified coming up to 9 months and I've got my bay and I've overseen a second bay ... On nights it's changed we're just mainly having D grades on night shifts and maybe, occasionally an E, they're now putting the D grades in charge on nights, not me yet they're the D's 6 months ahead of me so I suppose that will come up soon ... I mean it's a bit nerve wracking, I mean definitely on nights it's really difficult to get anyone to come up, but the NNP are really supportive especially if they know you're new ... skill mix has gone down on nights I'm on with two similar to myself or 6 months ahead of me, I mean you know now they're putting people 6 months ahead of me in charge on a late and on an early... (Interview: New RN Pamela).

Once the Ward Manager feels the new RN is 'OK' with the day-to-day work, the next landmark is being in charge of the ward on a Night shift. In the Surgical Directorate Ward Managers try hard to delay this landmark until about six months after the fledglings registration, so the eventuality of being in charge on night duty is planned well in advance and usually planned into the duty rota for one of the quieter weekend night shifts, unless of course someone goes off sick, a fear expressed on numerous occasions by the fledglings. Night duty has become the training ground which moves the fledgling truly into being accountable, and a capable RN, they know night duty is the acid test of their

ability, and a situation which looms with trepidation, evidenced by their keenness to get sight of the future month's duty rota from the Ward Manager.

After the acid test of Night Duty, and the increasingly frequent role of being in charge of the ward on a day shift, interest starts to kick in for some of the Junior RNs in terms of wanting to study for a degree. Post registration study is encouraged during the Juniors' appraisal with their Primary Nurse mentor, aspirations which are soon tempered by the Trust's increasing reluctance to support study leave or financial support to pursue a degree programme. For one Junior RN determined to be an Associate Nurse, advertised as **must have a degree (fieldwork document)*, on the backdrop of having experienced difficulties in obtaining study leave support to pursue the top up degree, she took matters into her own hands:

I'm doing my degree fairly early on because I heard on the grapevine that in time to come for promotion you're gonna need it, if you wanna get your Sister's post and things like that you're gonna need it, I'm doing it in my own time and paying for it ... it'll take longer ... (Interview: Associate Nurse Reanna).

For the odd one or two, they see the next grade, the Associate Nurse post, as a 'rite of passage', as Amanda explains, who after 18 months in the surgical wards felt entitled to promotion and recognition for the work she does:

I'm sick of being in charge on night duty and not getting paid for it ... it's a practical thing but the thing is I feel I've progressed and I feel happy, happier, but ... why stay at this grade, at the end of the day it's the fact I have to do it anyway ... (Interview: Junior RN Amanda).

After a period of being an Associate Nurse, during which many of this grade have had acting up experience, the next step is promotion to a Primary Nurse; but opportunities here are limited due to management's freeze on senior posts, and after implementing Agenda for Change (AfC) Primary Nurses (F grades) were re-graded at Band 6, followed by the floodgates opening by Trust managers regarding a skill mix review. The outcome of the skill mix review for the Surgical Wards was the issuing by senior management of new 'agreed'

staffing levels, demonstrating a dramatic decline in the numbers of band six RN posts across the Directorate shown in Table 22.

Table 22: Ward Nursing establishment changes at Primary Nurse / AfC Band 6 (fieldwork documents).

| Ward | Primary Nurse (Band F) beginning of fieldwork. | Junior Sister (Band 6) Following the skill mix review and ward reconfiguration. |
|----------------|---|---|
| <i>Renoir</i> | 4.72 | 2.00 |
| <i>Sheila</i> | 6.00 | 2.00 |
| <i>Degas</i> | 3.80 | Ward due for closure |
| <i>Monet</i> | 5.80 | 2.00 |
| <i>Klimt</i> | 4.80 | 4.30 |
| <i>Cezanne</i> | 1.00 | Ward due for closure |

For the Primary Nurses, role development and promotion, in the ideal world, would be in one of two directions: Ward Manager or Specialist Nurse, but after implementation of AfC, and the skill mix review, management took drastic measures: a freeze on all nursing vacancies across the Trust, the introduction of a process of reapplying for posts under the skill mix review, a downgrading of some Primary Nurses (band 6) to band five posts and displacement of Associate and Primary Nurses into other areas of the Trust. The ultimate clinical role in the Directorate structure is that of Modern Matron, but few opportunities are available for acquiring one, because there are no vacancies because management's philosophy is 'secondment' into or 'acting up' from the pool of existing Ward managers and Specialist Nurses'

**Role expansion dependent on shift of the day and day of the week:
the ward co-ordinator role.**

From Monday to Friday, during the hours of daylight, and providing the Ward Manager is not on annual, sick, maternity or study leave, each surgical ward is headed up by the Ward Manager, although even when on duty the Ward Manager

is often pulled away from the ward to attend meetings. Because surgical wards are open twenty four hours a day, seven days a week, fifty two weeks of the year [a week comprises 168 hours and a full time ward sister post is 37 $\frac{1}{2}$ hours], for 130 $\frac{1}{2}$ hours per week someone other than the Ward Manager is in charge, a role referred to in the Directorate as the Ward Co-ordinator.

Staffing the surgical wards in the Primary Nursing labour process requires a minimum of four RNs, one for each of the four teams, giving a ratio of one RN for seven surgical patients¹⁰⁵. So on a weekday if the Ward Manager is co-ordinator ** we need a minimum of four permanent staff to provide safe care for the surgical patients and me running the ward (fieldnotes - discussion with a Ward Manager)*. More and more often the ward is staffed with four RNs, so the most Senior Nurse on duty has to head up a Primary Nurse team at the same time as being the ward co-ordinator. Primary and Associate Nurses describe this as occurring more frequently, and a situation leading them to be constantly called away from their role as Primary Carer for their seven patients, because a team is headed up by an inexperienced new RN or a Nursing Auxiliary from the agency who **often has a 'big case in their bay'*¹⁰⁶ (fieldnotes).

The knock-on effect being the Senior RNs are constantly called away from their own patients and **no one does my patients care why I am doing theirs* as Tina explains:

Today I'm on a late shift and in charge ... and I have a bay [of surgical patients]. I have an [overseas] adaptation nurse in a bay, and a junior RN, and I have an agency Nurse ... so I am running my bay and there's no problem with my patients ... but the other bays I have to be checking up on them, pop in and check they're alright ... and again you've probably got a ward round or two to do, on the ward round they stand with you ... but they probably won't say a lot ... they're scared, so I have to know the whole ward, all the patients (Interview: Primary Nurse Tina).

¹⁰⁵ a bay and an additional side ward, the latter usually occupied by an extremely dependent patient.

¹⁰⁶ A big case: a colloquial term used to mean a patient who needs a lot of technical care or is in a situation where they require almost constant attendance by an RN eg a post-operative oesophagectomy, or bowel resection.

Being the co-ordinator of a shift is a big responsibility, and all about having to know every patient on the ward¹⁰⁷, and needing to know this so they can act quickly if a doctor arrives on the ward, or an emergency to deal with. The RN's role expands when they are ward co-ordinator because they have to support 'others' in their Primary Nurse bays, and in some cases they have to 'do the care' if the member of staff is unskilled in a particular task, or it is beyond their jurisdiction, which is frequently the case as they can often find themselves giving the IV drugs to every patient on the ward, alongside checking up on 'poorlies', and coping with a crisis.

Specific difficulties the ward co-ordinators have to deal with often occur at the weekend, as Sophie explained:

... during the week you'd be going around doing the ward round with the doctors and purely that, just giving a hand in the teams, and if they need bloods doing or drains taken out, doing that, depending on what staff are there. You probably move towards one end of the ward if there's a junior, or if there's quite a poorly patient ... then you have to leave the others at the other end [of the ward] ... it depends on your staffing, or if we've got an agency, an [assistant] grade agency you'll just be in that team because you know, if the rest of the ward is OK and there's juniors and an Associate Nurse you can feel quite confident they'll be OK.

Sometimes that doesn't happen, on the weekend there's more responsibility ... there's a lack of doctors, doctors aren't coming round as regularly as they would in the week, you can't get hold of them, sometimes there's not that support senior wise on a weekend, when you need to ask them something. You've always got your Ward Manager or your Specialist Nurses during the week, and you've got to get your TCI's beds, which is a nightmare on a Sunday so if you're in charge and have a bay you're still having to deal with all of this ... so that's three different roles ... it's dependent on the day of the week (Interview: Associate Nurse Sophie).

Having worked with Eloise on the evening shift before our planned interview I was able to further explore about her being in charge and having juniors in the bays the previous evening:

I had juniors in all the bays and you have to go and watch them. What happens more than having to go and watch them is they keep coming to you

¹⁰⁷ *their diagnosis, their past medical history, what operation they've had, how they were on return to the ward, what's improved or what has deteriorated (fieldnotes).

for advice which is good, the only thing is that you're the only senior person on [duty], you end up doing it literally ... every five minutes they're coming to you for advice, I had a bay as well ... I had a bowel resection post op ... plus a terminal patient plus one with a massive abdominal wound, I was the Primary Nurse for my bay. I was coordinating I'd got three juniors, I'd got [...] been qualified 9 months and [...] in the same group and a newly qualified ... Quite a few of my shifts it's the same and on nights its exactly the same, you have very junior staff with you, but it's not the fact you've got the hands, it's if you ask them to check something, they wouldn't pick up like me that there's something wrong, it shouldn't be that way, they won't pick that up because of their lack of experience (Interview: Associate Nurse Eloise).

The co-ordinator role regarding 'checking up' extends beyond interprofessional checking up [on the nursing team], to intra-professional checking, as illustrated by a Ward Manager who described her role as 'double checking':

most of the time I'm having to check up, check up on everything Junior Nurses do, and double checking on Medical staff , it's double the work because you're double checking your own staff, then you're double checking the medical staff and then you're ensuring when the anaesthetist comes down that they're made aware of the problems you've discovered, I'm the gatekeeper of everything, absolutely everything even medication whether its given or not given because the juniors don't tend to question or ask because they're nil by mouth for theatre they just put N on the treatment sheet whereas certain drugs can be given with a small amount of fluid which wouldn't affect their fasting - even the anaesthetic ... it's forward thinking but people can't think like that - they just say - they're eating and drinking so they must have their tablets ... and I really don't need a 40mg frusemide tablet given 1 hour before they're going for their angiogram ... you're putting together your physiology knowledge, and your years of experience with this current procedure because the older people can't drink the amount of water they're supposed to drink - I mean not many people drink 3 or 4 glasses of water a day ... as co-ordinator I'm running round looking at charts and things (Interview: Ward Manager Beth).

I further pursued what is different about being in charge, to being in the Primary Nurse team with two senior RNs:

I've got the two other people that are under me and anything they do ... anything they don't do, it's gonna come back on me. I say well - why didn't you look at it, why didn't you do this patient care, you know, it's gonna come back to me. I have full handover for the ward so I should know everything that's going on, on the ward, if there's a controlled drug error or if they go walking off or if there's a drug error made, it'll come back to me, they'll ask what I did at that point. I think it's a lot of added responsibility to take, to get paid six months ago the same as somebody who had just qualified ... I just think like I take on extra responsibility, but I'm glad in a way because

I've proved to myself I can do it (Interview: Junior RN promoted to Associate Nurse Amanda).

I had a bay as well, I had a bowel resection post-op, plus a terminal patient, plus one with a massive abdominal wound and I was co-ordinating i'd got 3 juniors, I'd got [...] been qualified nine months and [...] in the same group and a newly qualified, this is typical staffing quite a few of my shifts is for some reason and on nights its exactly the same, you have very junior staff with you, but it's not the fact you've got the hands, it's if you ask them to check something, they wouldn't pick up like me that there's something wrong, they'd take it automatically that I was right, whereas if you'd got another Associate or Primary Nurse is that right, shouldn't be this or shouldn't be that, they won't pick that up because of their lack of experience, I'm in charge as coordinator and have a bay, and I have to keep going round and check all the charts at the end of the day the buck stops with me and I'm in charge of that ward and of the 27 patients and I said I've got no qualms about checking anybody so its not the fact its personal, it's the fact you're in charge and things are going wrong, things aren't picked up ... (Interview: Associate Nurse).

Associate Nurses are finding that when on duty their direct carer role in the Primary Nurse system is becoming rarer than being in charge, as Eloise tells us:

its very rare I'm [not in charge] because you know we 'blob'¹⁰⁸ on the off duty, although it doesn't look, on the day time off duty your'e blobbed and you see spans [of the duty rota] where you're not blobbed, but on the nights you're always in charge, so really you're in charge, I mean I've been in charge for about seven times this month plus five or six on nights, about 14 shifts I've been on out of a possible 16, so although it doesn't look on the daytime off duty [as though you're in charge], you're in charge on nights as well, so the buck stops with me (Interview: Associate Nurse Eloise).

Role confusion and boundary disputes.

Whilst this study did not set out to focus its lens on Junior Doctors, an aspect of surgical care revealed through fieldwork was confusion and disputes surrounding the RN's role and responsibilities, in relation to Junior Doctor's role and responsibilities regarding the surgical patient blood test, venous cannulation and Intra Venous (IV) drug administration. The study revealed the substitution of basic skills and tasks, traditionally performed by Junior Doctors, to RNs, to

¹⁰⁸ BLOB: means the duty rota has been overdubbed with a pink highlighter pen indicating which RN is in charge on that specific shift.

be fraught with intra-professional confusion and disputes within the surgical wards.

There are numerous points in a surgical patient's hospital journey where a blood test is performed¹⁰⁹, and at a fundamental level this 'test' is a mere task, colloquially referred to as phlebotomy, but at a higher level can mean life or death, an investigation inextricably linked to medical diagnosis and prescription, because the results provide the basis for clinical decision-making.

To the unskilled / uncritical, phlebotomy is viewed as a one off task, but in the context of the surgical milieu and surgical patient care there are several hidden dimensions to 'the blood test', summed up in the following questions

- Who makes the decision a blood test is needed?
- Who decides when that blood needs taking?
- Who writes the blood request form?
- Who then performs the phlebotomy (and despatches if to the laboratory)?
- Who follows up to get the blood results if they are needed urgently?
- Who reviews the results on their return?

The boundaries between the medical and the nursing role in the context of these questions were found in this study to be confusing and blurred as to whose responsibility it is for the four stages involved in surgical patient blood testing:

- stage 1) the decision to prescribe a blood test,
- stage 2) the act of phlebotomy,
- stage 3) interpreting the blood test result,
- stage 4) action based on the interpretation.

¹⁰⁹ At the pre admission stage for planned surgical patients, the aim being to screen for abnormalities and correct these before planned surgery, prevents delays through diagnosing and treating abnormalities early.

Pre operatively, usually for the acutely ill / emergency patient, again to screen for abnormalities and treating accordingly. Many patients admitted as acute emergencies may have nil orally, or have been vomiting as a result of their surgical condition, others may have underlying tumours, notorious for altering haemodynamic status.

Post operatively because surgery evokes the stress response, the bigger the surgery / poorer / older the patient the more likelihood of disruption of haemodynamic status, so the need for the blood test is to monitor progress on current treatment post surgery.

When a patient's condition gives rise for concern.

To monitor certain treatments ie certain antibiotics, post transfusion and chemotherapy.

Conservatively managed patients, not requiring surgery eg, Pancreatitis, cholecystitis, some bowel conditions.

Phlebotomy is not a skill developed in RN training, in fact the history surrounding Senior RNs 'taking blood' in the Surgical Directorate was explained by Klimt's Ward Manager:

when [the previous DNM] was here, just after we implemented Primary Nursing the blood stuff came out, we were trained up and told to do it when needed there was nothing actually put on paper. The doctors expect us to do them all the time, no one ever said it was only our role ... it's when they expect you to do them it's a problem. Nowhere does it say on paper we have to take them (Interview: Ward Manager Kathleen).

All new RNs employed in the Rodin are up-skilled in phlebotomy following their appointment because it is not a skill learnt in their training; the Trust provides a theoretical session where they are able to practice the skill on models, but as one RN pointed out:

they don't put enough sessions on, so I learnt this on the ward and I'm beginning to do it on my own, I am going to do the theory session in May (fieldnotes).

There are mixed feelings in the surgical milieu as to the new RN's role in phlebotomy, as Faith pointed out, she did not feel the Juniors should learn this in their first six months:

We don't teach bloods [to the new RNs] in the first 6 months... I think that's a role above what we should be doing, I want to concentrate on the nursing issues ... a lot of juniors want to jump in and do things like that, and I have to tell them to calm down, and tell them that's something you can develop later, and I only do it if I think it's going to benefit the patient at that time, if it's something that can be left to the junior doctors, I'll leave it I only do it if its gonna benefit the patient... (Interview: Primary Nurse Faith).

In the Directorate the Junior Doctors expect the nurses to do the bloods, there is a culture of presumption on the Junior Doctors' behalf whereby they view 'doing the bloods' is not their job, as Molly explains:

Doctors, particularly the juniors think it's the nurses' job to take the bloods and not only those who come in as an emergency, but patients that require more bloods, repeat bloods. The way I look at it, its shared, if we're not busy we'll do them, if the Doctors aren't busy they'll do them, it shouldn't just be a Nurse's job because nobody was asked initially when our other manager was in post, nobody was asked do you want to do this, we were just sort of told you've got to. There's nothing in paper, the same with cannulation (Interview: Ward Manager Molly).

In practice this presumptive Junior Doctor belief system is fraught with problems as they have taken this presumption to the extreme, as illustrated from numerous incidents experienced during fieldwork:

Today I saw a Specialist Nurse picking up gaps in care, pointing out to the Junior Doctor bloods that weren't done, for example a patient who had a blood transfusion three days ago, the Specialist Nurse said the patient's blood count hadn't been requested and it should have been, she pointed to the entry in the patients notes the Doctor had written and he just shrugged his shoulders. For another patient who'd for ten days been nil by mouth, on a drip and had a naso-gastric tube which was still draining he also hadn't had any U&Es checked ... the Junior Doctor retorted stating I told the nurse to do them ... (Fieldwork with a Specialist Nurse).

This evening I witnessed a Junior RN being told off by a Junior Doctor for not having repeated a PTT which had been grossly abnormal, she then took the blood and sent it off urgently, the Junior Doctor then turned up on the ward and began questioning the Junior why she hadn't telephoned him with the result, he then walked off, the RN was upset and I asked her what was the matter, and she told me she had only just found out the results when she came to give the Warfarin ... (Evening shift fieldwork).

Some RNs have strong views that phlebotomy is not a part of their routine role as Denise explains:

Since I've come back on the ward as Primary Nurse I've tried very much not to take blood, because that is not a nurse's role, and with the essence of care I strongly believe the essence of care should be made to work, because that's basic, its not basic its essential nursing care ... we should be doing nursing for patients and if I'm doing bloods, if I'm making a decision to take blood, I'm not thinking has that man brushed his teeth, and also with the junior staff that we've got, if you're seen to be doing things like that that's what they want to be, they want to be technicians, they can't see that by taking the blood all they're being is a technician, because they can't prescribe blood, they can't prescribe fluids they can't change anything, all they can do is bring it to the doctor's attention, a technician could, and we're actually nurses and I wanted to be a nurse and make sure somebody was cared for ... I do it oh yes... this morning I've done it the man looked extremely pale and his last Hb was 9.8 and nobody thought to do something about it ... (Interview: Primary Nurse Denise).

With regard to the different stages of the surgical patient blood test the general feeling in the surgical nurse community is the RN should not be responsible for all the stages, because this can lead to a backlash:

... there's been times when there's been a House Officer, and he hadn't done a U&E¹¹⁰ for a patient and his potassium was up, and on the morning we picked it up prior to the ward round, and he came round, he'd said he'd forgot to do it, but he's done it before and we pick it up, so we're telling the doctor what to do, it happens, yeah, it does happen. They do the jobs on prescribing, they take the bloods from the computer and write them into the notes. I think that's something they need to do because obviously we're not able to recognise all the different things, that's where the difference is, they can look at a set of bloods and think ok, all we'll know is if the Hb's high or low, platelets high or low, you know the basics but we can't put it together, the bigger picture not like they can, no. I look at results and say ooh! I know that's not right and that needs to be seen to and shove it under their nose and say potassium's low ... and I can do that alright, and I know if a patient needs some blood, whereas they could, they've got that extra two years medical knowledge on us haven't they ... (Interview: Associate Nurse Amanda).

A common belief held by RNs is that if a Nurse initiates the taking of a blood test **You follow them up, if you ordered them, it's accountability (Fieldnotes)*, when this occurs for the RN it can be very time consuming:

taking bloods is not just taking blood, it's about making the diagnosis, it's also about writing the form, which is time consuming, then it's the taking it and then its following up the results... We follow up results all the time, we do it because the doctors don't and to be honest they don't see it as their role any more ... we are diagnosing if you suspect somebody is dehydrated, you'll naturally take bloods on them, if you see somebody bleeding you'll take bloods on them and we don't wait now for a house officer to come, because you'd wait forever (Interview: Primary Nurse Faith).

On a late shift an RN is looking on the computer for a patient's blood results so when the Junior Doctor arrives on the ward he can have the blood results to prescribe the fluids to be given IV (the drip rota), I ask her 'why isn't the doctor looking them up?', ** he won't do it, he'll just walk off, he'll come back later, but only when I've got the blood results (fieldnotes)*.

On another evening shift Primary Nurse Denise is at the Nurses' station sifting through the blood forms the Junior Doctors have written and left for the morning shift, some forms she is discarding she tells me

some of these routine bloods ordered by the House Officer aren't needed, the patient doesn't need them, it's a waste of money and time, it's not fair

¹¹⁰ U & E's: A venous blood test for Urea and electrolytes.

on the patient to keep doing bloods [the Junior Doctor] he didn't even look at his patients when he ordered them (evening shift fieldwork).

On the admissions ward Molly the Ward Manager recently stopped all her nursing staff taking routine bloods on new patients, in the interest of the patient:

we don't venepuncture admissions now as the doctor comes along and changes his mind, he wants more bloods, or no bloods, so we're not venepuncturing a patient twice, it's not fair on the patient (fieldnotes).

To draw a line under the disputes between Junior Doctors and RNs on one surgical ward, this was brought to the attention of a Consultant Surgeon, who after attending the ward team meeting agreed to include in the Junior Doctor induction to the Trust a session with a Senior Nurse on 'shared responsibilities' in relation to blood tests, cannulation and other aspects of care, an agreement the RNs were very pleased with.

In concluding the 'blood test' in surgical wards, as an exemplar of confusion and boundary disputes between doctors and nurses, Eloise, an Associate Nurse, provides a detailed account of the nuances and complexities of this aspect of practice:

there's a problem between whose responsibility it is, I mean, this is how funny it is, on the ward next door, nurses won't take blood Monday to Friday so that's fine. But when we have their patients [from next door on our ward], they [Junior Doctors] come round from their ward and they say can we have these bloods done please, doctors play the system, they expect us to do them, but their own actual ward staff won't do them for them, and they moan if they're not done ... on other wards some nurses will [do the bloods], so the Doctors are just sussing them out. OK, fair enough we do take blood if there's a clinical reason and the doctors aren't around I'll take them because, to me you're just using your clinical judgement, and even to suggest sometimes to doctors bloods to take. But if you take all these things on, and remember I'm training people in the ward, I have a big input with students, newly qualified, overseas ... what are the junior doctors doing ... it's not the fact you don't want to it's if you could actually... you know you can't do everything.

I've had an incident where there was a post-op lady and she needed bloods taking and the Doctor went to take them and couldn't get any, and she said do you mind doing them, I just can't get them out of her... so I ended up

doing the bloods for her, that's ok because it happens to nurses, but they need to learn, not just pass it on to us ... (Interview: Associate Nurse Eloise).

Peripheral venous cannulation is a skill increasingly performed by RNs and their views on this role dimension are both positive and negative. On a positive note an RN indicated:

... it's good I can cannulate because you then have respect for the patient with a cannula in, and it avoids a delay in treatment commencing, particularly with a patient requiring a blood transfusion. Although in the next breath she indicated her cannulation skills could be overstretched on occasions because of her increasingly being the only member of staff on the ward who has the skill and competence to insert a cannula (fieldwork with Primary Nurse Tina).

Whilst another RN viewed cannulation as part of but not exclusively the RN's role, because this aspect of care should be shared with the Junior Doctors, dependent on who is busiest:

I quite enjoy putting in a cannula, if I've got the time, if there's a doctor there that can put a venflon in, and I'm washing my patients and getting my patients up and sorted, I see my primary thing to get my patients clean, washed, basic nursing care, that is my priority to get that patient up and about, and if some of the doctors are about I will say will you put a venflon in, but then at night or on a late shift if I'm not doing anything and the venflon needs doing I'll happily put it in, but I won't do it because they've said to do it. If they're there, then they can do it, because I've got other things to do like dressings, whereas I would say to the doctor, will you do my dressings for me, you wouldn't do that, would you, because I'm pushing more on myself and I'm getting more bogged down, but if I'm not doing anything I can do it and I'll do it, I don't mind doing it.

As soon as you do those courses and you can do it, it's there. I never have any problem when I say will you do it and they will do it and bloods and things like that but, I've heard wind of it that they feel it's not their role anymore, that they don't think they should do it and if they don't do it, it's pushing another thing onto us. But I think it's gonna come back to like [a Trust hospital five miles away] they've got HCA's because we're getting all their jobs, who's gonna start doing all ours that's why they're bringing in NVQ and everything like that, that's what's gonna step up and I've know HCA's doing my training they do phlebotomy and everything like that (Interview: Associate nurse Amanda).

Changes to Junior Doctor roles and hours of work, with an increasing agenda of reducing their role in certain clinical tasks such as venepuncture and cannulation,

has for RNs in this Directorate increased the nursing workload, and for some creates antagonism towards the Junior Doctors

I feel angry at the Junior doctors' attitudes, they're evasive, idle, they blame the nurses when they should have done it (Interview: Primary Nurse).

Role contraction: the feeling Nursing is 'going backwards'.

The concept 'going backwards' in relation to nursing was mooted around at the beginning of fieldwork, when a Ward Manager at the first Sisters Meeting I attended where the issue of introducing NVQ training was being discussed, when one attendee made the comment **nothing's new, nursings going backwards it's the enrolled nurse by another name (fieldnotes)*. With the passage of fieldwork time I came to understand some aspects of nursing, Senior RNs believe are 'reverting back' to previous ways of working, ways of working they left behind as a result of introducing Primary Nursing, and becoming an all-graduate Senior Nurse labour force.

The most significant nursing area to be viewed as going backwards is the Nursing labour process Primary Nursing, created in the Directorate in the 90's, which is becoming increasingly difficult to sustain. A Primary Nurse explains that because management have not replaced her Primary Nurse colleague, loss of this one experienced RN made an extensive impact on the wards labour process:

Because [Jane] has not been replaced, me and another Primary Nurse have had to split the ward in half, we had to go back to Team Nursing, and it doesn't work, there's too much to do, too many patients (Interview: Primary Nurse Hannah).

A Ward Manager also agrees with this observation **I tell you just going back to team nursing for a month was a nightmare, hopelessly a nightmare (Interview: Ward Manager Lucy)*. Throughout the Senior Nurse community moving away from Primary Nursing is regularly criticized:

some wards because of the staffing levels decided they had to do away with Primary Nursing, now that's all very well, but task allocation is about the hardest to do, you actually use more leg work you use more time ... team is a little bit better, but I found you're looking after a bigger group of patients,

you are doing more running backwards and forwards particularly with theatre you might have the one nurse that goes for every patient. With primary nursing one person goes for their patients. You know, I would make sure I'd got the staff, even book agency staff to continue primary nursing ... but they're stopping us, stopping us booking agency ... (Interview: Ward Manager Kathleen).

Beth sees the changes in the labour process as inevitable, given the current Trust climate to cut costs:

The only way that you can get through the workload is to adopt task allocation, by doing task allocation you know that when you are very short staffed, to me, it's the most feasible way of getting patient care done safely, and you know every patient then has been attended to for the minimum sort of care for what that level of clinical skills that member of staff has got (Interview: Ward Manager Beth).

During a Sisters' meeting the Modern Matron expressed concerns it was not just Primary Nursing going backwards, but also the systems for nurse development because there had been no nursing audit for over a year:

... we used to do it annually and monthly, organisational and local, in the Directorate, and in the wards, the wards also had their own, we used to develop nursing based on the audit, but it's just been stopped, managers say we don't need it we do, but what can I do about it ? (fieldnotes).

Due to staffing constraints and the reduction in Junior Doctors' hours of work the Night Sister has been rebranded the Night Nurse Practitioner (NNP), and where they were once ward-based, and perhaps overseeing the adjacent ward, they are now covering the whole Surgical Directorate, six in-patient wards, Grace explains:

On night duty we used to have a Primary Nurse System and now they've got the old floor sister¹¹¹ back, it's back to where we used to be, nothing's really changed we're going backwards, it's how we provided senior cover 20 years ago (Interview: Primary Nurse Grace).

A now recently re-branded NNP, whose night duty career began as a 'floor sister', and who was previously a night duty Primary Nurse, a fieldwork example

¹¹¹ **Floor Sister:** A Senior Sister permanently employed on night duty, who visited each ward on a regular basis, supporting the in-charge student nurses when in their third year of training.

of how practice is no better than 20 years ago demonstrates how the new role is made more difficult by the lack of on call physiotherapy support:

There's a poorly patient on a night shift, we're called to review the man, the NNP immediately directs the ward nurse to ring switchboard for an on call physiotherapist, as it's obvious the gentleman is having difficulties breathing on his second day following bowel surgery, you can hear his chest is rattly with his every breath. The Doctor arrives and also says to make a referral for an urgent physiotherapy assessment.

Once the request is made it's the switchboard's role to ring the physio, which I'm told is now a voluntary service, switchboard rings back after 20 minutes and reports having rung eleven volunteers, and no one was able to come in to see the man.

The NNP then gives physio to the chest and afterwards says 'I gave physiotherapy to the best of my ability and I've filled out an incident form, this is not good enough' (fieldwork with a NNP).

A few days later I meet up with NNP and she tells me the incident form has been returned to her from the governance committee with a letter from the superintendent physiotherapist stating the patient did not need physiotherapy:

Physiotherapy service 'out of hours' is not available to an adequate degree - many surgical patients get chesty - it's part of the territory. Nurses are not trained to do physio - patients go off and there's no physio - many of the patients that go off are typically chesty, they have post-operative overload (fieldwork document).

The NNP was furious at this response

... the man at the time needed a physiotherapist, the physiotherapy superintendent wasn't in the situation looking after the patient, following the consultant's request ... I don't know what's going on, this used to happen years ago ... things are getting worse ... (Interview: NNP).

Not so much 'going backwards', but 'receding into the background' is another example in the surgical nursing community where Senior RNs increasingly feel they are becoming the Cinderella Nursing service in comparison to Nurses working in Critical Care, despite the two Directorates being part of the same Clinical Division in the Trust. Sophie illustrates this Cinderella feeling:

I do think it's a shame because they're putting all this money into critical care, they're getting all this fancy equipment, they're getting good training and I do think surgery and medicine is practically the same as geriatrics ... we're no longer the handmaidens to the consultant, but we're the

handmaidens to management and critical care (Interview: Associate Nurse Sophie).

The general consensus is that Surgical Nursing is now the Cinderella service in the division because critical care is valued as superior, examples of this being

... they walk into our wards but we have to ring their bell and wait to be invited in [into the critical care wards]

... the outreach nurse swans into my ward and sees patients without asking me, and I'm in charge

Feelings of inferiority are compounded by the fact critical care nurses wear different uniforms, and are allowed to wear slip-on mules; when the surgical nurses adopted a less formal footwear code they were 'told off', and told it had to stop

We received a memo to say we'd got to stop wearing slip-ons ... but we told the matron they wear them in the units ... she couldn't answer us, she was embarrassed, the business manager said it was health and safety ... (fieldnotes).

New RNs in Critical Care are supported from day one of being appointed by a Senior Critical Care Nurse whose full time role is internal support, supervision and training, and the fledgling's name is placed automatically on the study leave list to undertake the critical care specialist clinical course, a 'carrot' which aids recruitment. In contrast fledglings who have chosen a career in the Surgical Directorate find access to specialist clinical courses increasingly difficult. Table 23 contrasts the labour force environments of critical care nursing and surgical nursing.

Intensive Care, Coronary Care, and the High Dependency Unit (HDU) make up the Critical Care Directorate with each unit manned on every shift by a Senior 'critical care trained' RN, backed up with a defined ratio of RNs to patient dependency. The facilities inside each of the critical care units include a rest room, kitchen and a training room with state of the art computer systems.

The effects of 'difference' between the surgical nursing environment and that

Table 23. Contrasting critical care nursing and surgical nursing: Their labour force environments.

| Dimensions | Critical Care Nursing | Surgical Nursing |
|--|--|---|
| In charge of ward / department | Always a senior critical care trained nurse in charge | Increasing use of junior RNs as nurse in charge of ward |
| Post-registration specialist course | Must have critical care specialist course for promotion. Study leave for course attendance is a rite of passage. | Can be promoted without specialist surgical course. Declining availability of study leave. |
| Patient - staff ratios | Defined in comprehensive critical care. | No defined levels of staffing. |
| Patient dependency classification | Defined and used in critical care units. | No method in operation. |
| In-house training | Designated nursing posts for training. Also a practice development sister. | No recognised posts. RNs can access critical care training, but never any time to release staff from duties to attend. |
| Uniform and tools of the trade | Tunic and trousers. Slip-on shoes. Lap-top computer for outreach nurses. | Standard hospital issue. No slip-on shoes. |
| Access to unit / ward | Surgical nurse like visitor has to wait outside and ring bell for access. Swipe card / punch code. system for critical care nurses' access to their unit. | The door is always open. |
| Portering services | Portering staff will fetch equipment and blood for critical care nurses. | No special portering services. |
| Working conditions | Rest Room / staff sitting room. Training room with computer, PPT etc. Equipment +++. Relatives room | No rest room. Locker room doubles as toilet facility. No relatives room (bad news often given in sisters office). |
| Pre-registration / student nurse curriculum | Increasing evidence of critical care packages in the curriculum. | Declining amount of anatomy and physiology and common disease processes and surgical care. |
| National Support Mechanisms | BCCN ICCN RCN | NIL |
| Government Impetus | Comprehensive critical care | Waiting list targets <ul style="list-style-type: none"> • Surgical waiting lists • Trolley times in A&E |

of Critical Care is the exodus of both Senior and Junior RNs from the Surgical Directorate to Critical Care because the 'grass looks greener'. Additionally critical care want to recruit surgical nurses, particularly those who are capable, as it saves them time and resources teaching them the basics, like drug administration; Surgical staff feel:

... it's OK for us to do the initial training, the first six months , all the hard work - then they poach them and we have to start again ...(fieldwork with the CSF Primary Nurse).

RNs from Critical Care have expanded their role into 'Outreach' comprising Senior Sisters equipped with lap-tops, who visit surgical wards to check up on patients, and the surgical RNs practice, they appear autonomous and powerful, developing documentation systems for use by staff on the general wards, with what a surgical Ward Manager described as **no consultation (fieldnotes)*.

The relationship between the 'outreach' Critical Care nursing service and surgical ward RNs is best described as a 'clash of the Titans', what started off as a service run by senior Critical Care RNs has evolved into sending junior staff to review care on the surgical wards. The surgical nurses, particular Senior Nurses felt the service lacked partnership with the surgical nurses **they review patients without asking the primary carers for their input*, a feeling of superiority pervades throughout the surgical nurse community. When outreach services are discussed surgical RNs view it as a **filling over the cracks, sticking plaster service (fieldnotes)*, as opposed to 'strengthening the surgical service foundations':

... [outreach has come about] to identify patients that are becoming unwell earlier so they don't deteriorate, it's because some nurses couldn't do that without a score on a piece of paper, you know I can tell when someones going off, but the new juniors can't, MEWS gives them the ammunition to be able to say look there's something wrong with this patient ... that's been a very positive thing about outreach ... (Interview: Primary Nurse Grace).

Even in the student nurse community the Critical Care team are having an impact on the curriculum by insisting a team of lecturers and Critical Care nurses develop a five day skills based training programme, which eventually led to a

module comprising practice study days, critical care clinical outcomes, although there was no equivalent for surgical nursing in the pre-registration curriculum. The final straw came when a Critical Care Sister attended the Surgical Sisters' monthly meeting, telling those present **we're now providing training for venepuncture*, a message received with concern because after the meeting surgical nurses were found to be discussing **why can't we provide our own training, we've got the expertise, they're our patients (fieldnotes)*. A major development was that the Critical Care Division started providing a range of training programmes for nurses across the directorate shown in Table 24.

Table 24: Training provided by the critical care directorate.

| Number of days | Title of training |
|----------------|---|
| 5 | High Dependency (HD) programme. |
| 1 | Cannulation. |
| 1 | Drug administration. |
| 1 | Acute Life - threatening Events Recognition and Treatment (ALERT) course. |
| 1 | Immediate Life Support (ILS). |
| 5 | Care of the critically ill surgical patient (CRISP) course. |
| 1 | Venepuncture |

Surgical Nurses did not just critique Critical Care's current domination in the nursing arena but offered their suggestions as to the reasons why this was occurring, all of which seemed to come back to the 'de-skilling' of current fledglings due to changes in their pre-registration preparation. Senior and junior RNs regularly compared their training to that which is currently provided, with some stating that although they were P2K students, **I wasn't like they are on qualification*.

Existing RNs all hold views on the current RN training. A Ward Manager sees the decline in disease-based knowledge, and the minimal amount of surgery in the curriculum has a knock-on effect on the wards, and her concern as to the educational led university approach to current training:

it's a shame really, because as a surgical nurse I can't understand how they can nurse someone whose had an appendicectomy without knowing where the

appendix is ... how do they know where it's gonna hurt, how can they possibly nurse someone when they don't know which bit they've taken away. Students go off stressed for days because they've got an assignment due in, we haven't had brilliant support from the University (Interview: Ward Manger Lucy).

Some nurses' roles are felt to have contracted, for example the Juniors role now in comparison to when the seniors were juniors

They do less on qualifying than we ever did, patient care hasn't changed, the needs of an appendix, it's to do with their training. It's all about comparing my training with theirs, the new ones we've appointed (fieldwork).

The stable element is the in-patient surgical patient; surgical patient needs have not changed but if the course preparing someone to be a nurse on a 'general' surgical ward does not include much on surgical patient conditions and associated nursing care and does not include long surgical placements:

The surgical theory and practice has hardly prepared you for the reality of practice. So where does that 'gap' in your surgical knowledge and skill now have to be filled - by ward based senior surgical nurses i.e. on the job (training model), cascade training, sitting next to Nellie (interpretive memorandum).

Tina, during the final interview, the Primary Nurse on the busy urology ward, was asked if she felt her role was expanding:

Yes and no. because our big cases go to HDU or ITU and I feel that leads to us being quite de-skilled, they always used to come back to us so you've got central lines, catheters, pumps, this that and the other now a central line automatically goes to HDU or ITU and in that way I feel I am being de-skilled, we get patients with pumps and you struggle a bit cause you think blimey I haven't used one of these for ages and you panic a bit ... again they're taking a few skills off you ... (Interview: Primary Nurse Tina).

A resume of evidence supporting the **nursing is going backwards* feeling in the surgical nurse community is shown in Figure 60.

Figure 60. The feeling Nursing is 'going backwards'.

- Primary to Team nursing: Due to the shortages of RNs.
- Task approach v Holistic care when short staffed.
- The NNP is the old floor sister.
- Re-branding the DNM to Modern Matron.
- No nursing audit.
- Essence of care - back to basics (why isn't care improving).

Future role aspirations.

Despite all the pressures Junior and Senior RNs have to cope with within the surgical milieu, they expressed aspirations in two areas where their role could further develop in the future: prescribing and bed management. On examining current practice in these two areas, only minor changes would lead to legitimizing the current 'hidden talents' of surgical RNs because both areas are where RNs feel they have already expanded their role, the problem being that it is not recognized. Aspirations for further role expansion were voiced against a backdrop of two concerns: would patient care suffer? and what do Junior Doctors get paid for?

In relation to prescribing, Senior RNs were already influencing their patients' prescribed medications:

We're already doing it, we're reviewing medications, we tell doctors what to prescribe, we're putting up IVs when the rota runs out, we're putting up saline before blood, we write up the TTOs and the doctor just signs them (Interview: Primary Nurse Faith).

The Junior Doctors are in the habit of **nursing station diagnosis and prescription*, where RNs place 'post-its' on the patient's prescription chart during the medication round, signifying to the doctor the prescription needs updating. The RNs also leave notes on the prescription chart for the doctor indicating abnormal blood results and to remind the doctor to prescribe IV fluids, which can for some RNs result in a frustrating situation **Junior Doctors do the changes without seeing the patient*.

The prescribing rights Senior RNs want are routine aspect of surgical care and include ** the IV rota, the routine surgery drugs, and the TTOs ...* and they are also keen to be able to discontinue medications instead of them being given longer than needed:

I mean, I think there's a case for nurse prescribing, you know on a ward like ours, things like analgesia, subcutaneous heparin. I think if somebody comes in on medication I don't see why nurses can't prescribe that medication to

continue through the patient's stay ... I wouldn't allow prescribing to every member of staff, it would have to be Primary Nurse grade and above (Interview: Primary Nurse Grace).

In terms of prescribing the short stay Ward Sister sees there is a role for her:

I feel confident to start prescribing, because my patients are for routine surgery, things like giving routine enemas as a pre-op bowel prep, they've got to have their enemas or the surgery is cancelled, and laxatives, post-operative straight forward analgesia when they've [the medical staff] only written up an opioid and you need a covering oral I mean I'm not going into things like antibiotics, its just a mid range of general laxatives for this area, bowel prep and analgesia and maybe IV rotas, and can you do so and so, ... re-prescribing if the treatment sheets run out, just re-writing it eh, perhaps writing medication up for patients that have come in with their drugs in front of them, routine drugs (Interview: Ward Manager Beth).

The Junior RNs also saw they had a future role in prescribing, which would legitimize current practise where they put up a bag of IV fluid when the drip rota has run out, or where they commence saline before a blood transfusion:

I think we should be allowed to be able to give paracetamol, if a patient has a temperature at night, because it's jobs like that, that Dr's won't come out for, they won't, they'll give a verbal message to give it, you know anyway to give it ... eh ... IV rotas and enemas and when like some rotas I mean the NNPs say to put up saline anyway but, you've usually got it in your hands anyway as they're telling you to do it I need to keep the drip going ... the way I see it is, when you give blood, you run saline through the giving set anyway you're giving that without it being prescribed anyway when you give a flush, you're giving that without it being prescribed, so why can't I just put a bag of 250 saline to tide me over till the Doctor prescribes it (Interview: Junior promoted to an Associate Nurse Amanda).

The Specialist Nurses are the keenest to become prescribers, their main reason being to ensure continuity of care for the surgical patient, as Amy explains:

... I'd like to prescribe laxatives, basic pain control, because the doctors don't understand a lot on stepping-up medication. I saw a lady the other day on the ward who's on co-codamol, she's not having it regularly, she's having it PRN so it's a hit and miss so they've gone straight to tramadol, if they had given it her regularly, assessing it, seeing whether a combined approach with an anti-inflammatory or something else before moving up to the next level. There doesn't seem to be any logic how the medics prescribe... it could be they're [junior doctors] because the ward staff are telling them what to prescribe and they haven't got the knowledge, they're saying prescribe tramadol and it's the nurses' lack of knowledge about pain and it has a knock on effect (Interview: Specialist Nurse Amy).

Amy further illustrated how becoming a prescriber would help her to fulfill her role in the nurse led clinics she runs:

With my patients I see in my nurse run clinic, I see people post-op and it's usual there's constipation and usually nausea, pain and bowels - those are the three main things, with the Whipples they come back and tell you oh I've got my 'floaty motions' and he just needs some cream prescribing so I have to write to the GP and get the GP to prescribe it because I can't prescribe ... My role will be limited if I get the dyspepsias on board [a proposed new nurse-led clinic], into the clinic on a Thursday. I've got to be able to juggle with the medication. But if I wanted to change something I can't do it, so what's the point of me trying to see a patient in a nurse run clinic when I have to go and find a doctor to write up the prescriptions. It makes a mockery of it. So yes you're saving a clinic appointment for a doctor but the doctor then has to go and do 2 jobs at the same time so that's why I think it's frustrating to the medical staff that they're employing us to try and make their job easier but they have to do twice the amount of work. Our manager doesn't understand prescribing (Interview: Specialist Nurse Amy).

The second area for development is Nurse-led bed management, which the Ward Manager of Degas sees as having always been a part of her role, but is currently expanding:

... it has always been there ... the nature of surgery is there are waiting lists and emergency patients, but the increased emphasis on not cancelling and increasing throughput has resulted in us doing more bed management (fieldnotes).

The general feeling in the senior nurse community is that nurse led bed management is already going on in the form of 'juggling beds' to accommodate admissions, but the Seniors want to develop this aspect of their role into admission / TCI management, avoiding inappropriate TCIs /undetected problems which lead to last-minute cancellations and when inevitable replacing cancellations. Furthermore Seniors want to further develop nurse-led discharge, currently a well-kept secret in one ward, for fear of retribution, a hidden talent where the consultant surgeon sends a coded message to a Ward Manager that once the patient is 'OK' they can go:

Nurse-led discharge ... we do a lot of that at the weekend, our consultants don't mind, so long as they've put home in the notes and we're happy with the patients we let them go. You have a set of criteria in the back of your head ... perhaps if they're a TURP, had their catheter out, voiding urine, they're not wet, fluid balance OK, making sure they're not retaining more than

200ml in their bladder, I actually ask them are you happy to go home, have they got anyone at home, what transport - you know, as long as I feel they're physically fit and they're happy and I look at the fluid balance and temperature (Interview: Primary Nurse Tina).

While there are these aspirations for role development there are also negative comments, and most of these come from the specialist nurses who commented **I can't do any more, *there's restrictions on my practice*, I pursued what these statements meant and their responses were not surprising:

... not being allowed admitting rights, despite running nurse-led clinics
... receiving more and more new referrals so they can't fit in their visits to their ward patients
... doing more paperwork to meet the government targets
... writing protocols for the Chief Nurse, so I can't get on with my normal work

Extending the working week

On a backdrop of policy implementation, reduced skill mix, rising surgical patient dependency and a drive to increase surgical patient throughput, RNs agree there is more care than they can fit into a shift. What have therefore evolved are two ways in which the working week has extended; first, the physical extension of the hours worked by RNs either through working overtime or by taking work home; and a second more worrying psychological effect because for many RNs the 'too much to do' environment results in many of them being unable to 'switch off' having left the ward.

The extended hours of unpaid RN work came to light on Renoir:

It's a late shift and I've come on duty early for the night shift ... the late staff appear really busy - the Primary Nurse is getting a trolley ready to remove a Chest Drain in the team where the newly qualified RN is working - she hasn't seen this procedure before so only the Primary Nurse has the skills of chest drain removal (and me so I agree to be the Primary Nurses' assistant in the chest drain removal procedure). The lates are all busy finishing off all the jobs that have to be done that day. I ask why are we removing a chest drain at 9 p.m. the Primary Nurse said she couldn't get round to doing it earlier, anyway it's the idea of a 24 hour day - as long as it's delivered it doesn't really matter what time ... it's now 11pm and the day

shift Primary Nurse is still on the ward ... catching up on her paperwork (fieldnotes).

On a night shift where I again walked onto the ward early even though I am used to the routine because it is a year into fieldwork, the ward looks like there are plenty of staff on the late shift:

I notice the Primary Nurse is here and I remember handing over to her at 7.30 this morning because I was also on duty last night ... I ask why is she still here ? ... because the ward is so busy and all the staff on duty are fairly junior, and there's a particular problem because a patient has been given bad news and the relatives wanted to meet with her she agreed to this although she was just going off duty. They arrived 15 minutes later and went into the sisters office, the time is now 11 p.m. when she went home, she'd had nothing to eat and worked a total seven hours overtime (fieldnotes).

One of the junior new recruits, six months into their role was asked if he ever found himself going off duty late:

Yes, regularly because, for one I wouldn't like to give the person coming on a whole load of jobs, you know I know its 24 hour care but sometimes they're very busy in the ward so you don't do the care that is frankly for your shift and I wouldn't like it, otherwise it would be 8:10 shifts I would be saying well I haven't done that for 2 o'clock, I haven't checked his catheter, I haven't done this or that, and it would go on and on ... (Interview: Junior RN Ethan).

Molly the Ward Manager has had an extremely busy evening, managing admissions and helping staff out on the adjacent ward because they have some very poorly patients, she has to have a report ready for the meeting tomorrow:

I work over ... and I take work home, yeah and they [management] don't see that, and I'll probably be taking this home tonight. My lifes not improving ... obviously the intent is to start doing that, that's what management say, improve working lives but they don't know what goes on (Interview: Ward Manager Molly).

All the senior nurses seem to take work home. As one Ward Manager explains, there's nowhere on the ward she can concentrate:

I always take the duty rota home and anything secretarial, in fact anything where I have to concentrate if I need to concentrate (Interview: Ward Manager Beth).

Cheryl outlines the type of work she needs to take home:

I take home off duty, this is the big one, anything that I need to type up, cause I haven't got a decent computer on the ward, anything that I want to

put in a nice format I'll take home, anything secretarial (Interview: Ward Manager Cheryl).

In an effort to try and understand why RNs experience stress regarding their role, this was pursued on a one to one basis, with the majority attributing it to being frustrated at never feeling they have completed their work to a satisfactory standard:

when I go off duty I feel I have done only half of the work I should have done. I wake up at night and ring the ward to check I've done something (Interview Ward Manager Degas).

The times you leave the ward and you don't feel you've left it sufficiently staffed. It's all about the cover on the ward, are they experienced enough to know when somebody is going off, it's knowing when somebody is going off (Interview: Primary Nurse Faith).

You are always going home thinking - I haven't enough hours in the day - I haven't done everything I should have done, but there wasn't enough time..... it's a good shift when no-one dies, no-one comes to any unavoidable harm (Interview: Fledgling Ethan).

The effects on the RNs of working in an environment where there is too much to do is that they are upset and some even experience feelings of anger:

I was angry with myself, blaming myself, why didn't I check up, I was also angry with her ... if I'd had the time ... (Primary Nurse Hannah).

I ruined my teeth, grinding them, this is how I coped with it, people don't want to be a [ward manager] because there's so much on their plate (Ward Manager Beth).

The Juniors also have views on the pressurised surgical environment they are working in:

I think there's too much pressure on the juniors. and when you get anxious, and you get rushed you make mistakes... then you get blamed for making mistakes... and you go home at night worrying. All the time I go home worrying. I phone up some nights and say I haven't done this, and I think everybody does (Interview: Fledgling Amanada).

For some RNs their stress begins before even arriving on a shift:

Sometimes it's the dread of coming in on the next shift, the dread of managing the dependency, especially if you have no help ... I look at the off duty before I go off, to look at whose on with me on the next shift ... if I'm

on with juniors or an agency I dread coming to work (Interview: Acting Primary Nurse Sophie).

Conclusion Part III.

This study explored the RN role in an Acute Trust hospital non-Critical Care Surgical Directorate, at a time of modernization of the NHS brought about by New Labour NHS Plan (DOH 2002). A study conducted at a moment in time when demands for surgical services were rising, simultaneously Junior Doctors' hours of work were being reduced under the EWTD. Through using the ethnographic approach the assumption was that it was possible to capture RNs' responses to modernization through studying their role within Rodin's Primary Nurse labour process, the findings of which were presented in Part III.

Part IV: Modernization and the 21st century Registered [Surgical] Nurse.

Part IV turns to interpretation of the ethnographic findings. Chapter 7: The Registered [Surgical] Nurse and modernization in Rodin, provides a 'local' interpretation of the findings, before embarking on Chapter 8: The 21st century role of the RN in the Acute Trust, which provides an interpretation using sensitising concepts discerned from Braverman's (1974) skill substitution thesis outlined in Figure 2, p.21.

Chapter 7: The Registered [Surgical] Nurse and modernization in Rodin.

The concept 'NHS Modernization' evolved following launch of New Labour's NHS plan (DOH 2000a), after which came a cascade of policies requiring Acute Trust Hospitals to implement targets to reduce surgical waiting lists, targets for fast-track cancer patient referral, and targets to reduce emergency admissions waiting time in A&E. Alongside the introduction of these targets to improve efficiency and effectiveness in Acute Trusts, NHS modernization is also about shifting the balance of power from Acute to Primary Care Trusts, including the introduction of a mixed economy approach to the provision of health services in England. Mounting evidence suggests New Labour's modernization agenda is 'privatization of the NHS through the back door' (Pollock 2004; Mandelstram 2007), as services once provided within the NHS are increasingly contracted to private companies. The consequences of this privatization trajectory are not as yet fully realized, and beyond the remit of this thesis.

For NHS employed RNs modernization of their role was promulgated when the Chief Nurse issued '10 key roles for nurses' (DOH 2001a), followed by government's targetting of RNs through clichés like 'liberating the talents' (DOH 2002a), and the 'skills escalator' (DOH 2002d) , all urging NHS managers and RNs to 're-design and extend roles' (DOH 2004a) through 'new ways of working'. For RNs working in non-critical care Acute Trust surgical wards, where the lens of this research was focused, in addition to managing the modernization agenda, they have had to respond to New Labour's introduction of two strategies in response to public and professional concern regarding the quality of hospital patient care; Comprehensive Critical Care (DOH 2000) and the Essence of Care

(DOH 2001b). Two costly innovations¹¹², some experienced RNs during fieldwork referred to as

knee-jerk policies, implemented without government or the nursing profession questioning 'why is care not improving ? (fieldnotes from a Surgical Directorate Sisters meeting),

at a time when there is unprecedented financial investment in the NHS, one would presume care would be improving.

At the start of fieldwork Rodin's aims were for excellence and expansion in clinical services, and as an Acute Trust it was undoubtably ambitious regarding modernization, evidenced by its securing of centrally allocated monies for a new regional cardiac centre and becoming a recognised Medical Student training centre two years earlier than anticipated. Rodin's Senior Management predicted a growth in their labour force of five per cent over the coming five years, and their Strategy for Nursing indicated there would be recruitment of more nurses, a reduction in the number of vacant nursing posts (at any one time), strengthening of their links with the local university provider of pre and post registration nurse education, and development of a modern career framework aimed at removing the barriers for career progression, enabling a Nursing Cadet to reach Consultant Nurse position. Overall the nursing strategy promised an 'improvement to the working lives of Rodin's RNs', shown in Appendix 29.

Rodin's strategic aims and philosophy, displayed and promoted throughout the Trust, were somewhat tempered by middle (non-clinical) managers, whose operational philosophy was **modernization within a limited, if not reducing budget (fieldnotes)*, evidenced in the themes 'cost containment' and 'cost reduction' discussed in Part III, agendas reinforced to RNs through overt and covert authoritative tactics, for example turning up on the ward and questioning

¹¹² **Costly Innovations:** RN time is the most costly aspect of the NHS (so we are told), yet critical care nurses have had to spend valuable time manning the outreach service, whilst ward-based RNs have had to spend valuable time implementing essence of care benchmarking, time they felt could be better spent delivering specialist care to patients, relatives and supporting future trainees.

Ward Managers' decisions regarding employing agency staff. Covertly the middle management team reduced the Senior Nurse labour force on a month-by-month basis, without consultation with the Modern Matron or the Ward Managers. Control of the nursing labour costs in the Surgical Directorate was achieved (by non clinical managers) through a process of placing a freeze on Senior Nurse vacancies followed by their substitution with less costly Junior RNs, resulting in slow erosion of the nursing skill mix. Because monthly nursing establishment spreadsheets were distributed to Ward Managers from the Divisional Managers office by 'snail mail', with a covering slip **requiring immediate checking and return (fieldwork documents)*, Ward Managers did not keep copies of these, but because I was on the distribution list I did; analysis of these provided the evidence to support the assertion managers were in control of nursing labour costs through a process of 'sequential erosion'.

One explanation of the construct 'sequential erosion' evolved following investigation into the causes of the USA space disaster 'Challenger'. A proposition emanating during the post-disaster investigation was that space programmers were found to be trying to 'do more and more with less', as a result of a 40% decline in the money allocated to the space project, combined with a change in how that money was spent. The movie 'Challenger' (2006) made after the disaster acknowledged sequential erosion was a plausible reason for the disaster, with some project staff suggesting:

we don't accept it, we get used to it, almost without knowing it we lower our standards each time, till they become rock bottom (*Challenger* 2006).

A situation which led one analyst to suggest, 'budget cuts mean short cuts' (*Challenger* 2006).

Due to the freeze on Senior RN vacancies Ward Managers brought into play compensatory mechanisms like 'acting up roles' to ensure their wards had Senior RNs as co-ordinators, although it was made clear to the applicants these were

temporary positions, with no increase in pay or grade. A further tactic to ensure additional non-clinical workload requirements in the Directorate were met, was for Ward Managers to allocate to Senior RNs additional role dimensions, making them into 'Dual Role' RNs, pulling them further away from their direct patient care role in the Primary Nursing labour process.

Simultaneously with the overt cost containment and cost reduction tactics put in place by non-clinical managers to reduce nursing labour costs, clinically based RNs received covert messages that the cost containment and cost reduction principles did not apply to Rodin's non-clinical workforce. Messages which came in the form of employing increasing numbers of non-clinical staff, including a circa £30,000 fraud officer, contracting with consultancy firms, creation of numerous audit clerk and clerical positions and finally the pervading of the Trust with Service Improvement Teams¹¹³ (SIT's). Each new administrative, clerical and management recruit, to function effectively, was provided with a computer, office space, access to a telephone and other work related tools of the trade. During fieldwork the rising number of non-clinical managers and their support entourage relocated into a state of the art refurbished building, taking with them the only photocopier and secretarial support available within the vicinity of the surgical services, both of which were called on constantly by clinical, front-line surgical staff.

The most extreme example of the chasm between clinical staff and middle managers was seen when the popular Business Manager resigned; on his last day of employment at the Senior Nurse meeting a small gift and a short speech was given by the Modern Matron. On walking over to the Business Manager's office, to collect some important data for this thesis, I walked into a 'full-blown leaving party' attended by support staff and managers, but no surgical nurses; on pointing this out to the Divisional Manager I received only a 'pulled face'.

RNs also received messages from medical staff. From Junior Doctors these were often conflicting, for example some Junior Doctors showed a willingness to perform clinical skills, such as the administration of intra-venous drugs, insertion of a peripheral cannula, male catheterisation and venepuncture; whilst others were blatantly obstructive, indicating to RNs their role as **I'm still in training (fieldnotes)*, which RNs found irritating ** they're salaried by the trust, they should do the bloods, they can see how busy we are (fieldnotes)*. The Consultant Surgeon messages were more consistent and more assertive, in the form of wanting to be informed if 'things are not going well', in two particular areas: the management agenda, and issues affecting the care of their individual patient. With consultants expecting, and on many occasions demanding RNs to ring them directly to inform them of such problems.

Senior RNs felt particularly bombarded with the message 'there's a need for modernization', through managers' constant use of the cliché 'new ways of working'. A cliché Senior RNs felt implied their current mode of production to be old and outmoded, yet as they pointed out, prior to New Labour launching the NHS Plan and the Chief Nurse launching the 10 key roles for nurses, they had in the Directorate embraced many of these supposed 'new roles', through 'moving with the times'.

Senior RNs during recent years had set up new services (Hospital to Home), up-skilling their roles and at the drop of the non-clinical managers hat were re-deployed to head up newly created wards (Cezanne and Degas). New wards which meant two experienced surgical RNs from the major in-patient wards were re-deployed, both developing the infrastructure to work in new ways in the form of nurse led admission and discharge. Pre-admission surgical services¹¹⁴ had

¹¹³ **Service Improvement teams (SITs):** Teams employed under the NHS modernization agency agenda as change agents, under the umbrella 'Service Improvement'.

¹¹⁴ where waiting list surgical patients are assessed prior to admission for surgery, the goal being to identify and manage risk factors, preventing unnecessary and increased length of stay in hospital due to unforeseen patient problems being identified after admission.

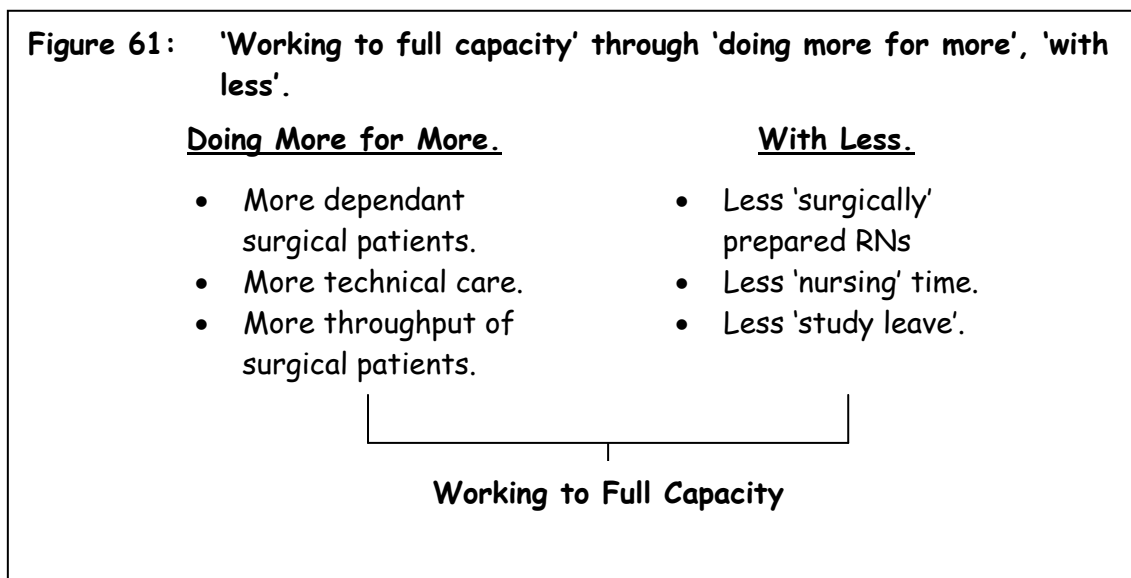
dramatically increased in Rodin, headed up by Senior ward-based RNs, skilled in rapid and in-depth patient assessment in the context of the planned surgical procedure, a service improvement which pulled experienced RNs away from their Primary Nurse roles. A service initially trialled for the duration of an Out Patient session (3 hours), but because it proved so successful was formalized, with Klimt's Primary Nurse permanently relocated to provide pre-admission urology clinics, leaving the Ward Manager with a frozen senior nurse vacancy. For Klimt this development was particularly difficult to manage due to the creation of the 'virtual urology ward', which had to be staffed by Klimt's remaining Senior RNs.

Because new RNs have not developed the skills of venepuncture, intra-venous drug administration, male catheterization or peripheral venous cannulation during their three year training, on being employed in Rodin they are quickly up-skilled through internal training provided by staff from Critical Care. The transference of tasks previously performed by Junior Doctors to surgical ward RNs is most evident on night duty, where Night Sisters have been re-invented into Night Nurse Practitioner's (NNP), a role carrying with it upskilling in verification of expected death and ECG recording, alongside this the NNP is the practitioner ward based RNs have to ring to avoid disturbing the Junior Doctor during Protected Sleep Time (PST).

These so called 'nursing developments' in Rodin's Surgical Directorate have come into being because Senior RNs have no choice but to respond to management and medical demands. RNs are 'sandwiched between' the power of the medical profession and the power of the Trust's senior managers, who discharge the government modernization agenda. RNs are likened to a 'sponge', absorbing government and medical agendas, in the context of no increase in RN staffing as a result of management's cost containment and cost reduction strategies, a contextual background which resulted in anticipated and unanticipated consequences.

The 'anticipated' consequences of modernization for Rodin's surgical RNs.

On entering Rodin's non-critical care surgical wards, surgical RNs were found to be in an era in which their role is in a 'state of paralysis', a 'status quo' position where there is neither expansion or contraction. RN's are just about managing to cope with the ever-increasing workload they are faced with. The findings suggest RNs in the surgical milieu are coping with non-clinical managers emphasis on resolving targets and responding to government and local policy, against a backdrop of a case mix of in-patients who are increasingly dependent and more rapidly admitted and discharged. Interpretation of the findings from this study culminates in reporting RNs are 'working to full capacity', through 'doing more for more', 'with less', depicted in Figure 61. Constructs which are now explained.



'Doing more for more'.

RNs in the surgical wards are delivering more care for more surgical patients as a result of changes to the provision of surgical services in Rodin. The development of a dedicated Day Surgery Unit, and a short stay surgical ward (Cezanne) was as a response to the government's drive towards segregating elective from emergency surgery. The consequence of these developments has led to the four surgical wards (Degas, Monet, Renoir and Scheila) experiencing

the greatest impact from the Trust management's service re-design agenda. Additionally, and in response to the need for beds to be freed up in the Critical Care Directorate [ITU and HDU], quite dependent surgical patients are transferred back to the surgical wards, patients who require skilled RN care due to their ongoing complex needs, including their older average age and presence of co-morbid conditions¹¹⁵, resulting in the need for additional skilled care because of the effects of surgery and anaesthesia on chronic medical conditions.

Rising surgical patient dependency is a factor Senior RNs have repeatedly tried to explain to management, but **their constant reply is prove it (fieldnotes)*, which over time has culminated in a Senior RN 'taken for granted' acceptance of their inability to prove [in management terms statistically] patient dependency in the four wards has risen¹¹⁶. This situation is compounded by Senior RNs no longer being allowed to use the dependency monitoring system¹¹⁷ which was for over a decade used as part of the Nursing Audit system following implementation of Primary Nursing. RNs therefore have no means of providing either comparative data or current data on patient dependency and throughput to support their requests for an increase in RN staffing.

Patient dependency is not the only reason RNs are 'doing more for more', it is also about the nature of the surgical workload distribution in the Directorate, as extracts from fieldwork illustrate:

The short stay ward has changed the nature of the bed occupancy on my ward.

We've employed more consultant surgeons therefore we have an increase in the number of big surgical cases per week we have to care for.

There are more elderly emergencies and they are surviving the surgery.

¹¹⁵ for example Chronic Obstructive Pulmonary Disease (COPD) and Diabetes.

¹¹⁶ Someone like myself with a lengthy background in surgical nursing is skilled to judge / calculate patient dependency on walking into a surgical ward and receiving a nursing report, I can through experience confirm patient dependency has risen dramatically over the last five years.

¹¹⁷ **Dependency Monitoring Systems:** the major tool used in the Directorate on implementation of Primary Nursing was MONITOR.

There is an overlap of big surgical cases, the bowel surgery cases take ten days to recover before discharge yet we have a weekly operating list. Patients are transferred from HDU more dependent because there is pressure on critical care beds. We have totally dependent patients, often terminal because there's nowhere for them to go.

The number of emergency surgical admissions has also increased, which includes people stabbed, shot or wounded due to rising violent crime in Rodingham. Emergency admissions, combined with the major elective surgical cases, culminate in the need for more technical care for each and every surgical patient, technical care in the form of fluid administration, pain relief, wound and wound drainage management and the recording and interpretation of clinical observations. To illustrate this point, the technical care for one post-operative major elective surgical patient for an eight hour shift is briefly outlined in Figure 62.

Figure 62: Technical requirements for an 8 hour shift for a first day post operative bowel resection patient with a stoma and diabetes.

- Continuous intra-venous (IV) fluid administration and fluid balance management
- Four hourly intra-venous (IV) bolus antibiotic administration
- Pain relief / pain management
 - Patient Controlled Analgesic (PCA) pump / Refilling of PCA
 - Pain assessment / re-assessment
- Hourly observations and their interpretation
 - Pulse, Blood Pressure, Pulse oximetry, MEWS, Urine output
- Diabetic management
 - sliding scale insulin administration
 - 1-4 hourly blood glucose monitoring
- New Stoma management
 - Observation of stoma for complications
 - Stoma care

Even with the advent of electronic devices (PCAs) for the administration of pain relief, these technology supported devices take up RNs' time to monitor and manage them safely¹¹⁸.

Realization of the increased amount of technical care for surgical patients is by the Senior RN labour force, because they are skilled and professionally responsible / accountable for surgical patient care, and the eyes and ears of the absent surgeon. RNs in Rodin's four major in-patient surgical wards are increasingly finding themselves in a situation of being a technical carer and risk manager, because there is an increasing reliance on a transient workforce of agency and bank staff, who plug the gaps in regular ward staffing. Permanently employed Senior and Junior RNs are increasingly finding themselves in situations where they are detecting concern about, and deterioration in a patient's condition, they feel should have been detected earlier, and having to then call the 'outreach' critical care team and the admitting surgical firm.

Management's greater emphasis on reducing the length of surgical patient stay (LOS) means RNs have an increasing amount of work created by earlier patient discharge, and of course their replacement with new admissions, most acutely seen in Cezanne. A further innovation to increase the Surgical Directorate's capacity occurred in Degas, where RNs created the 'hospital at home' service. In real terms Degas 28 bed in-patient urology ward is now full of dependent / needy patients as a result of discharging earlier TURP patients, thus increasing ward patient turnover. The 'hospital at home' service has at any one time 30 additional urology patients who require experienced nursing support either over the telephone, or from a home visit, an innovation which increased RN labour

¹¹⁸ For example use of a **PCA device** for administering pain relief requires more frequent patient observations due to the potential side effects of controlled drugs. Added to which is the physiological fact major surgery evokes a response where fluid is retained post-operatively, part of the body's natural adjustment to the surgical stress response, as diuresis occurs the concentration of controlled drugs in the bloodstream can increase, inducing severe respiratory side-effects, if undetected can lead to grave surgical outcomes.

force requirements within existing resources. Reduced LOS means urology ward beds are occupied by more patients, more patients means RNs have more admission and discharge processes to fulfil, more patients undergo surgery, so more time is needed for technical care in the form of clinical procedures, recording of clinical observations, rehabilitation and information to ensure safe surgical patient discharge.

With less.

'With less' is interpreted in three ways: firstly there are less Senior RNs in the Directorate who are deemed 'true' General Nurses prepared for a role in caring for the adult medically and surgically sick; secondly, there is less RN labour force time for the delivery of holistic care in the Primary Nurse system; thirdly and finally there are less study leave opportunities for the new, generalist RNs to obtain education to facilitate their specializing in surgical care.

There are less 'General Nurses' prepared under the traditional apprenticeship for care of the acutely ill medical and surgical hospitalized patients (SRNs or RGNs) who were prepared at certificate level and then followed the 'catch up' opportunities on implementation of Project 2000. In Rodin Primary Nurses were enabled to 'get educated' making them an all-degree, speciality-based, surgical nurse labour force, providing care for an increasing throughput of surgical patients of which an increasing number are very dependent.

The decline in the number of true surgical RNs is in the main due to their disillusionment in terms of their working conditions and their exodus from the Surgical Directorate because the grass looks greener in other NHS health care arenas. Once RNs resign, management places a freeze on these Senior Nurse vacancies, followed by converting these posts to junior grades, cheapening care costs, and a process referred to by RNs as backfilling.

Although the Trust's philosophy was to appoint new RNs on completion of their training, their 'Generalist' preparation means they are less skilled in care of adult surgical patients, because on registration they are the product of a health-based pre-registration curriculum, therefore experienced Surgical RNs invoked compensatory mechanisms in the form of the surgical competency development programme to 'train up' the fledglings, to cope with the requirements of their role in the acute surgical wards. Although an admirable development by the Directorate's senior nurses, is, at the end of the day, internal training which can lead to the 'see one, do one, teach one' scenario, particularly because senior RNs are leaving and their vacancies are filled with newly registered recruits.

In addition to being 'generalist' RN recruits to the surgical wards, the new Adult RN is additionally de-skilled in care of acutely ill surgical patients because of their increased reliance on the 'outreach' critical care service, and the widespread use of the 'MEWS' approach to detecting patient deterioration, brought about by the DOH (2000b) Comprehensive Critical Care strategy. A reactionary strategy / approach to solving more fundamental problems in the preparation of adult RNs for their role in acute patient care and the increasing use of assistant grades on hospital wards where increasingly dependent patients are housed. Junior RNs learn to rely on the outreach nursing service, as opposed to Rodin supporting them on post registration surgical courses, which would educationally underpin their chosen area of clinical practice, like their counterparts are supported in the Critical Care Directorate.

For Junior RNs employed in the surgical wards there is internal training, but the opportunity for study leave to pursue a top-up degree related to surgical practice, which was up until recently in the Directorate supported by the

trust¹¹⁹, and a 'rite of passage' to being a senior RN is now on hold. The previously top-sliced budget for post registration nurse education in the NHS is rapidly in decline, some RNs tell me in the last month this has been slashed by 50%. The knock on effect is that RNs who choose to pursue a career in surgical (or medical) wards are disabled from pursuing a programme to educationally underpin their clinical practice. In contrast to their colleagues pursuing a career in critical care nursing, who are immediately put forward for the degree in critical care nursing clinical practice, hence there is no rite of passage to becoming a surgical nurse.

Presently backfilling in Rodin's Surgical Directorate is with Generalist prepared new Adult RN's, although moves are afoot for a new backfilling strategy following the appointment of an NVQ training co-ordinator, who made her initial mark with the Surgical Ward Managers by asking them to nominate RN candidates to become NVQ assessors for the proposed Health Care Assistant (HCA) programmes. Although the Ward Managers were initially opposed to this request, they were further disillusioned as their nominee RNs were interrogated regarding their professional qualifications regarding assessment by the newly appointed non nurse NVQ co-ordinator. Senior RNs concerns extend beyond the nuances of the new NVQ system in Rodin, because their real and more fundamental concerns relate to the fact they feel they just cannot cope with any more competency development programmes, or supervision requirements.

The construct 'with less' is finally applied to there being less 'RN' labour force time to deliver holistic care in the Primary Nursing system. RNs in the Primary Nursing labour process are finding themselves increasingly delivering task-based

¹¹⁹ RNs prepared through a General Nurse apprenticeship for care of the adult hospitalized sick in the wake of P2K were in this Trust supported to pursue diploma and degree programmes in surgical nursing. A result of the 'catch up agenda', and the increased availability of post registration education, stringently assured by the ENB. With inception of the NMC, came demise of the ENB and loss of professional recognition for post-registration clinical courses in hospital specialties.

care because of the Junior Doctor skill substitution agenda, the up-skilling agenda has resulted in more technical care for the RN labour force to deliver to surgical patients as a result of substituting tasks from one occupationally employed group of staff in the surgical milieu to another. This is compounded by the implementation of the Junior Doctors Modernising Medical Careers (MMC) strategy in the form of the new FY1 and FY2 Junior Doctor.

Less holistic nursing time is also attributed to RNs having to respond to the modernisation agenda, through their role becoming a dual role, these added on role dimensions inevitably remove them from direct surgical patient care and their supervisory role with juniors and transient workers in their wards, as a result of being pulled into new services for example pre-admission and 'hospital at home'. This situation leads to a dilution of expertise on surgical wards, against a backdrop of increased patient dependency and throughput (in the management drive for cost containment and cost reduction). The RN's dual role means that instead of 'just' being an RN delivering direct care to surgical patients, they are increasingly expanding their role into ward management in the form of shift co-ordinator, because the solitary Ward Manager works 37.5 hours per week, and when on duty is often drawn away from the ward. To get through the work demands RNs are allocated additional role dimensions, extracts from fieldnotes indicate this is a common approach to respond to managements demands within the existing labour force budget:

Kate an Associate Nurse is allocated two mornings per week to enter data into a computer on risk reports in the Surgical Directorate.

Mary a Primary Nurse spends two days of her working week as a specialist GI Nurse due to the need for the service to accept rapid referrals from GPs. She tells me last year 159 patients were referred to the nursing service and in just the first four months of this year we have received 100 patient referrals, we had to pull the team together ready for the cancer review.

Alice a Ward Manager is placed for two weeks in an Acting up position whilst the Directorate Nurse Manger is off sick, and as a knock on effect Jane a Primary Nurse has to act up for the ward manager for the next two weeks.

Emma has been released from her Primary Nurse role for two days a week into the Clinical skills facilitator role.

Three urology ward RNs have Hospital to Home roles, taking them away from the ward for anything between half to three days a week (fieldnotes).

Allocating additional responsibilities to RNs is a cultural practice effective in maintaining, even lowering labour costs, but at what expense? These dual roles mean RNs are pulled further away from their role as direct patient carer in the Primary Nursing System, and as a result of backfilling Junior RNs are learning their 'secondary', co-ordinator / supervisory role is more important than their 'primary', direct patient care role. The outcome of the dual role approach to getting through the workload is that RNs are soaking up modernization agendas with no consideration for the effect on surgical patient care. Nevertheless management are happy because RNs are coping with modernization without additional costs to the Trust, as a Ward Manager summed it up **I'm now carrying a ghost (fieldnotes)*, a term she used to refer to her ward being devoid of two shifts a week of a senior member of staff, all in the name of development.

Working to full capacity.

Modernization of Rodin's surgical nurse labour process has resulted in Senior, experienced RNs 'doing more for more with less'¹²⁰. The increased patient dependency and patient throughput on surgical wards has resulted in paralysis in the surgical nurse community, RNs can neither expand nor contract their role because they are just getting through the workload. The preceding five year growth culture in Rodin's surgical milieu now culminates in the point at which expansion demands exceed the capacity of RNs to respond. RNs can not cope with any more demands on their role, as evidenced by the chaotic responses seen to a small anomaly in day-to-day ward functioning, when an RN rang in sick:

¹²⁰ as a result of managers' erosion of the nursing skill mix, against a backdrop of increasing numbers of more dependent surgical patients and an increase in the throughput of patients.

... this morning a staff nurse rang in sick for the late shift, the ward co-ordinator went into overdrive to cover the late shift, ringing staff on their day off and ringing other wards to see if an experienced RN was able to do an agency shift (fieldwork).

The overall effect of the sequential erosion of Senior RNs is a reduced nursing skill mix to care for an ever increasing dependent surgical ward case mix. Yet to the untrained eye, surgical wards seem well-staffed. This illusory façade of 'uniforms' manning surgical wards is a situation rarely detected by the average patient or visitor, it is a staffing illusion. Surgical wards appear well-staffed to the untrained eye, because employees don uniforms once traditionally the domain of RN's and their assistants, yet today, apart from the Ward Manager, many staff wear uniforms of a similar nature, whose distinguishing features, their 'symbols of difference'¹²¹ which indicate their provenance and grade, for the majority are indistinguishable to patients, relatives and many others, because the symbols are hidden from view due to the almost permanent use of plastic aprons. Rodin's ancillary staff are now wearing the 'old' navy blue Ward Sister's uniforms, and a new grade of assistant in the ward the old Enrolled Nurse green uniforms, which adds a new perspective to the concept 'recycling' in the NHS.

The 'unanticipated' consequences of modernization for Rodin's surgical RNs.

On the surface Rodin's Surgical Directorate RNs are proud of their responses to modernizing surgical services. Below that façade is a sense of concern 'all is not well' in the surgical nurse community, emanating predominantly from their recognition they can no longer sustain the Primary Nursing labour process. The overwhelming feeling is that Nursing is 'going backwards'. Changes brought about through modernization of surgical services and the modernization of RN training, compounded by the Junior Doctors Improving Working Lives (IWL) agenda have culminated in unanticipated consequences.

¹²¹ the badge, belt and for males epaulets.

Going backwards.

The Primary Nursing labour process, embedded in Rodin's Surgical Directorate for more than a decade, headed up by Senior, all graduate surgical RNs who supported and supervised the supernumery, next generation of student nurses, return to nursing students, overseas recruited nurses and any other group of trainees passing through their surgical wards, have responded to, and coped with, increasing patient dependency and patient throughput, but this can no longer be sustained.

In the interest of safe, surgical patient care, Ward Managers have been forced to revert to Team Nursing, and on some shifts because Team Nursing can no longer be sustained, tasks are allocated to ward staff to get through the work. On many shifts the only regular RN on duty is the shift co-ordinator. This solitary RN's only option for getting through the technical care required by patients, for example the administration of intravenous drugs, is to become that technician. On night duty the labour process is most affected, RNs have been forced to revert back to a traditional model of Senior Sister cover in the form of the Night Nurse Practitioner (NNP), who, instead of working on one ward and overseeing the adjacent ward, now covers all six surgical wards, consequently one RN is supervising more patients and more staff.

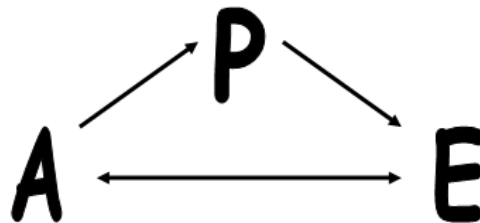
Primary Nursing came into being as a result of nurse training moving into higher education, whereby the apprentice student nurses were replaced with RNs. The holistic Primary Nursing labour process meant a Primary Nurse assessed the surgical patients' needs, planned their care, implemented that plan of care and evaluated the outcomes. The acronym which evolved in the nursing profession to symbolize holistic care was APIE¹²², previously depicted in Figure 6, p.34. In

¹²² **APIE:** Assessment, Planning, Implementation and Evaluation (APIE = holistic care under primary nursing, APE = the current RN role, I = the role of the new assistant / un-regulated grade of staff in hospital wards).

Rodin, the Primary or Associate Nurse delivered APIE, holistic, individualized care on a continuous basis. Increasingly in Rodin the 'I' is moving towards a domain of either a transient workforce of assistants to the RN in the Directorate, made up of agency staff, many of whom are student nurses 'moonlighting', or the new HCA grades. As a result of modernization surgical patient care is becoming fragmented, the holistic APIE model has become the 'APE' and 'I' model depicted in Figure 63.

Figure 63: Fragmented care delivery the APE & I model.

a) The RN Role.



b) The 'assistant' role.

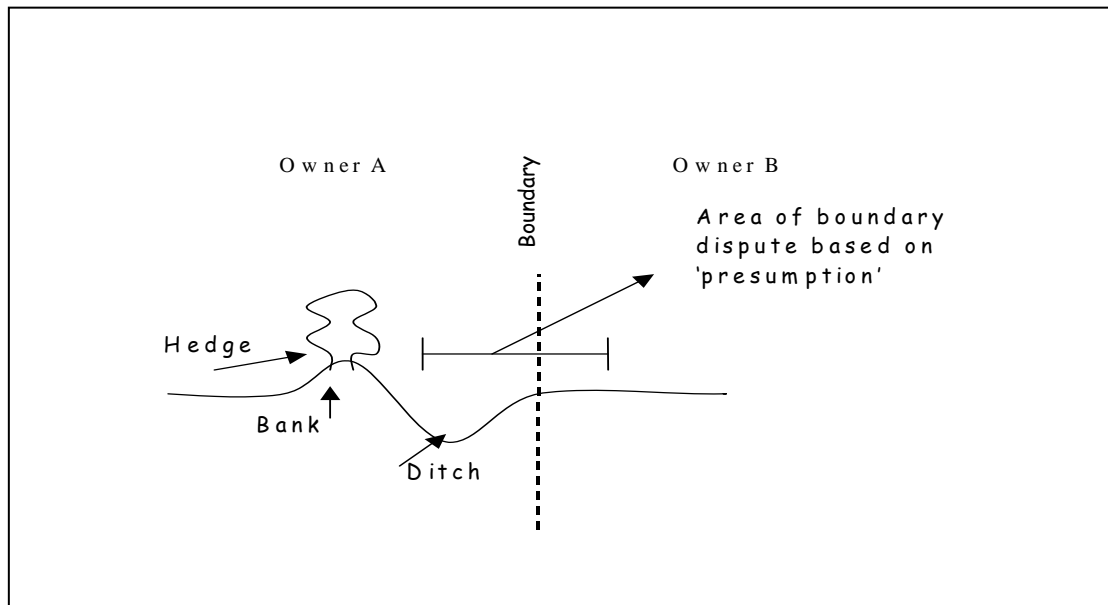
I

Boundary disputes.

A further consequence of modernization in health care and an unexpected effect of the Junior Doctors' longstanding campaign for Improved Working Lives and career modernization was found in Rodin's surgical wards, that of occupational boundary disputes, where Junior Doctors and experienced RNs are in dispute because each feels it is the other occupational group's role to perform aspects of surgical care, particularly in relation to the surgical patient blood

test. Boundary disputes in the legal world of property are referred to under the 'the hedge and ditch presumption', a presumption which comes into force when owners of land adjacent to each other become in dispute, depicted in Figure 64.

Figure 64: The hedge and ditch presumption (adapted from Davies 1979).



From support and supervision to a culture of surveillance.

The RN culture in Rodin's Surgical Directorate is one of being supportive. In addition to being a supportive environment the RNs formal role as supervisor of 'others' is embedded, but due to RNs having to cope with an increasing number of the labour force who require formal and informal supervision, against a backdrop of dwindling numbers of experienced RNs who are truly capable of performing this important role, those remaining are becoming saturated with the requirements to be a supervisor. A situation forcing Junior RNs to become supervisors at a point in their career some feel is **too much too soon (Interview Junior RN)*. The RNs performing supervision are usually Senior RNs, but due to management's backfilling Senior Nurse vacancies with less experienced RNs, Juniors have to take on the role of formal supervisor, earlier than one new RN expected:

I qualified in October and I did my practice assessor workshop by the end of the month. I just got put on it..... when I first had a student I felt worried, I feel more confident now to have a student than I did - but it was a bit of a shock ... (Interview: New RN Amanda).

Senior RNs have tried hard to compensate for the difficulties newly recruited RNs experience in their first few months following appointment to the workforce, particularly in relation to 'getting themselves organized', as a Ward Manager explains:

I try to match the task to the skill ... for the level of clinical skills that member of staff has ... I take away all the peripheral work, the decision making, the discharge arrangements, chasing up reports and X-rays ... so I tend to take that kind of pressure off them because I think they're very stressed, and the thought of having to look after two bays of patients because of staffing levels its hard enough as it is to keep on top of the work without worrying about arranging discharges, finding a treatment sheet then getting the TTOs and then find the treatment sheet after its been written up to make sure it goes to pharmacy ... (Interview: Ward Manager Beth).

But an aspect they cannot control is the need for Juniors to be supervisors of student nurses and untrained staff due to the recent skill mix changes. In addition to the RNs being supportive, and formally being supervisors for several groups of nursing staff, RN's were seen to be informally supervising Junior Doctors and Medical Students 'in the interest of safe patient care'.

The Surgical Nurse culture of 'caring for colleagues', manifested itself beyond individual surgical wards, as evidenced by staff from Degas (the Surgical Admission Ward) whose RNs show particular concern for colleagues on the four 'heavy' in patient wards, despite their being under constant pressure from management to 'bed manage' through decanting patients to the major surgical wards. Before decanting these patients Degas RNs check the staffing situation on the ward they are proposing to transfer a patient to:

if a junior's in charge I try to delay the transfer, I try to ensure as much care is given and documented before transfer ... Specially if it's a poorly patient which could lead to added stress for the Junior (Interview: Associate Nurse Degas).

RNs from Degas were very aware of the pressure on the four major in-patient surgical wards, because this is where they had all worked prior to Degas opening.

Being a formal supervisor is a dimension of the RN role stretched to the limit, as Hannah explains:

... at the moment I've got a Return to Nursing student on a six month course, I've got a new overseas nurse, and another overseas nurse going through a six month preceptorship with me ... I've got the students that come through the doors anyway, because none of the juniors want to do the [supervisor] training ... so they can't have students. Sometimes it adds up to four students at one time, plus the Juniors [new RNs] going through their 6 months preceptorship as well, plus co-ordinating, plus having seven patients doing Primary Nursing ... and I'm a tidy person too, I like the place to be tidy (Interview: Primary Nurse Hannah).

The increasing use of agency staff in the Directorate to plug the shortfall in permanent staff, and because managers insist on the lowest grade of agency staff being used, are further factors contributing to the rising need for supervision:

[we have lots of agency nurses] lots ... but that's another way our role has changed, we're employing [unqualified staff] to cover [Junior RN] vacancies, so then you've got to supervise them as well, whereas if it was [an RN] grade you wouldn't have to supervise as much ... if we actually calculated it I'm supervising student nurses, new RNs, overseas, return to practice ... on top of that medical students now (Interview: Primary Nurse Grace).

Plugging the gap in ward nursing staff with agency staff is fraught with additional problems for the regular RNs due to the uncertainty as to the quality of the practitioner sent from the agency:

I've had a lot of agency ... when you put requests in you get somebody you don't know, it is difficult if you don't know them from before ... sometimes it's been better just to do it yourself ... sometimes it's just better not to have anybody, given what they've sent you (Interview: Ward Manager Molly).

Supervision of Student Nurses is also becoming increasingly demanding due to the tension between academic and practice demands on the student, as Lucy outlines:

... making them [student nurses] totally supernumery was a bad move, some of them think supernumery status is, put their hands in their pocket at the end of the bed, I've done two bed baths and I don't need to learn anymore ... whereas if they're hands on and if they we're salaried maybe, but then I'm going right back. They have little surgical content [in the curriculum] which is a shame really, because as a surgical nurse I can't understand how

they can nurse someone whose had an appendicectomy if they don't know where the appendix is, how do they know where it's gonna hurt ?... How can they possibly nurse someone when they don't know which bit they've taken away

Has the educational responsibility shifted to ward staff ?

I reckon so, they're so stressed out, the students go off stressed for 2 or 3 days because they've got an assignment due in and to be fair, we haven't had brilliant support from the University ... in fairness [...] if they have a problem with a student who may need referring, and you do ring the link tutor, they come over and try and turn it around, and there's many an occasion where we've tried to refer ... and its so frustrating, the girls know they're dangerous practitioners, but it's a nightmare to get them referred (Interview: Ward Manager Lucy).

An additional way of filling vacancies in the Trust has been to recruit overseas nurses. To obtain NMC registration the overseas recruits undergo a programme of supervision by an experienced RN whose ultimate role is to 'sign them off' as competent for entry onto the NMC register, a supervisory role which takes up considerable preceptor time as a Ward Manager illustrated earlier in the thesis.

The informal supervision of Junior Doctors is also time consuming for RNs, whose major concern seemed to be the 'laissez faire' attitudes of some Junior Doctors to patient care. An example being what has become referred to as Junior Doctors **nursing station diagnosis and prescription (fieldnotes):*

Junior Doctors don't bother to go and see the patient, they diagnose from the nurses station, they prescribe without going to look at or speak to the patient, and they rely on us to tell the patient their treatment's changed (Interview: Associate Nurse Sophie).

A surprising feature of Senior RN practice was that of 'double checking', a supervision dimension of the RN role that was increasing, as a Ward Manager confirms:

Yes ... most of the time I'm having to check up, check up on everything junior nurses do, and double check on the medical staff ... (Interview: Ward Manager Beth).

The meaning of 'double checking' was pursued with Beth as a result of shadowing her on an operating theatre morning when two patients who had been assessed

by a Junior Doctor were ready to go to theatre. I found Beth frantically calling the Junior Doctor back to the ward because there were omissions in the prescriptions so she could not check them out for theatre, I asked her if this was common practice:

It can happen quite a bit actually, it's double the work, this is why you end up double checking - you're double checking your own staff, then you're double checking the medical staff. I'm gatekeeper of everything, even medications, whether it's given or not given because the juniors don't tend to question or ask (Interview: Ward Manager Beth).

Lucy a Ward Manager, is acutely aware of the supervision requirements of her Primary Nurses and how this is interfering with their direct carer role, concerns she expressed to management:

you can come to saturation point, that's why I've had to speak to [the Assistant Director of Nursing]. I'm very conscious of the fact the seniors on here are becoming saturated, they're not saturated yet, but I can see stress levels rising ... that's why I try on Monday to Friday to do as many hours as physically you can do, so it leave the Primary Nurse with the hands on. Now they can do an awful lot of one to one teaching at the bedside, the problem occurs when they've got a student and a return to nursing - and an [overseas nurse] so I have to be very conscious of the rostering (Interview: Ward Manager Lucy).

Supervision of new RNs has been a statutory requirement for a number of years, but the concerns of the seniors is not with their formal supervision role but the fact they are increasingly detecting inappropriate Junior RN practice which leaves them in a position where they feel they have to 'pick up the pieces'..

they [the juniors] only have so much knowledge, you go to them and they tell you twaddle, I find that very alarming. They sow misconceptions in the patient's mind ... I had one who gave some information to a lady and then went on holiday, and the lady rang about her father, she'd said to this lady your father's got cancer and I've got to pick up the pieces, at that point he hadn't had his histology back so I just spent ages picking up the pieces on that, I did manage to sort it out, but very alarming (Interview: Ward Manager Kathleen).

The Senior RN's role as a supervisor has now moved up a notch to one of surveillance, there are two possible reasons for this. First, RNs are becoming saturated with the need for formal and informal supervision on a backdrop of a declining skill mix and a cycle of staff change. Second, and a more worrying

explanation, is that all the RNs in this study had experience of finding 'undetected / unreported patient problems', two factors culminating in a culture of checking up, a culture of surveillance, indicated by the constant vigilance by RNs at all grades in the Surgical Directorate ... as a Primary Nurse illustrates:

I'm responsible for looking after student nurses, new D's, Overseas Nurses, Return to practice ... I suppose I'm responsible for the auxiliaries, their medical knowledge isn't that good, and also relatives, they ask us things and you've got to listen to what they're saying - because they're probably not 100% sure of what they're talking about ... and they say something that they shouldn't ... and so you've also got to be on your guard ... I had a new girl pick up the phone the other day to a patient's son and she must have asked how she was, and she said oh fine, she's been seen, had a cystoscopy, got a bladder tumour and ... oh my chin hit the desk, I just couldn't believe what she said so I had to see her ... and I'm like 'aah' [hands in air] (Interview: Primary Nurse Tina).

Primary Nurse Hanna explains why, when she is co-ordinating the ward, her role has moved from being a supporter and supervisor of staff and patients into a surveillance mode:

I can be in one part of the ward and at the 'other end' of the ward things are going on and I am not being informed ... (Interview: Primary Nurse Hannah).

a story expanded on following a night shift, where at 3am Hannah walked through the ward after caring for a poorly patient and identified a patient's condition had deteriorated in a bay being managed by a Junior RN:

she got his MEWS score to three, but I'd got it to seven ... I said again I think his MEWS is seven [she said] no his MEWS isn't seven, so we looked through the chart together, she got the chart with me and she argued with me over ONE point about his urine output, because his urine output was adequate ... I went into overdrive his condition was dreadful... I told her to bleep the physio, I told her to bleep the registrar on call because it was a Saturday and I told her to bleep the outreach team ... she said she hadn't done his dressing yet and I said his dressing doesn't matter his dressing can wait do this, but she didn't, so I did it myself cause I wanted it sorted straight away, the registrar came straight away and the outreach team came and within an hour he was ventilated

Do you think this gentleman ... if you had been the person looking after him, perhaps their condition might not have deteriorated so much, before you sought help?

Yeah ... I'd have been able to identify it sooner, an hour earlier, Yeah - if I'm co-ordinating I still expect them to come to me with a problem, or if they're bleeping a doctor I want to know who they're bleeping a doctor for, I wanna know what's going on ... I just wanna know what's going on, because I'm the boss ... I felt, I felt, she can't do her job very good, I felt that, I felt I was quite upset about it and angry, angry with her, and I was upset and angry with myself - because why didn't I go to the side ward why didn't I go and look at his chart an hour ago (Interview: Primary Nurse Hannah).

The surveillance culture extends into action in the form of surgical nurse persistence when Junior Doctors do not seem to be performing to the standard they expect for their patients. This was seen by RNs as Junior Doctors contracting their role, as evidenced one morning with a Specialist Nurse whilst 'doing her rounds', she was picking up omissions in routine care in relation to blood requests she felt Junior Doctors should have done:

I was picking up the bloods this morning that haven't been done [Why ?]. Because it all comes back to they [Junior Doctors] haven't got the interest they used to have, I mean, when you and I were on the wards, they'd come and look at the bloods before the ward round, the bloods now stay on the clip¹²³ for days, unless the nursing staff say such and such bloods are abnormal. To me it shouldn't be up to the nursing staff, we work as a team and if I have take a blood test, or if I ask for a blood test, I follow it through. The medical person that's asked for that blood test, they should follow it through, if the patient attends a pre-assessment clinic and he's asked for pre-operative bloods it's up to that houseman to look at those bloods, its not up to me. But that's what's happening, the Nurses are picking it up (Interview: Specialist Nurse).

The surgical nurses have become what in the construction business are referred to as 'snaggers'¹²⁴ because surgical patient's conditions are deteriorating and the signs and symptoms are not being detected early enough, which the RNs view as omissions in the caring role. Even with all the 'will in the world' the ability of Surgical RNs to 'make a difference' is limited as a result of the firefighting culture which has evolved. There is no room for surgical nurses to manouvere their role, a paralysis or status quo situation has evolved which has

¹²³ On the clip: to the practice of blood results being returned to the ward and placed on a bulldog clip ready for medical staff to review, prior to filing them in the patient's notes.

¹²⁴ Snaggers: A role usually performed by the works manager or project manager which comes into being when the hired help claim to have completed the job ... the 'snagger' goes round and

led to boundary disputes because surgical nurses are struggling to maintain the standards of care for their surgical patients on a backdrop of the demands on the role being made by middle management, which mimic the government modernization agenda, hence RN role development, expansion and extension in their traditional senses are a thing of the past. The rising need for supervision and support of junior RNs and other staff on the wards has led to RN saturation, on a backdrop of a declining skill mix and the cycle of staff change culminates in a surveillance culture, passed on from the Senior to the Junior RNs.

'RN silence' in Rodin.

The final unanticipated consequence found as a result of this ethnographic journey was 'Nursing Silence', or, 'loss of the surgical RN voice' which manifested at my first Sisters' meeting, where the agenda was dominated by government policy and modernization in Rodin. At no point in the meeting were patient care or nursing issues discussed. Nursing silence also extended into the multi-professional clinical governance meeting where patient morbidity and mortality is discussed, even though several Senior RNs were in attendance, none of them spoke; on walking back to the ward I enquired why, and received an unexpected response * *if I do speak my contribution is not listened to (fieldnotes)*.

The need for RNs to cope with and respond to the dominant management agenda of policy implementation and cost containment has resulted in the 'silencing of RNs'. Some reasons for RN silence in the presence of non-clinical managers gleaned from fieldwork include:

... *i'm too frightened to speak out,*
... *management don't want to listen to my contribution,*
... *we've heard it all before, nothing gets done,*
... *it's a waste of time,*
... *we fear retribution,*
... *I don't feel management are concerned about nurses' welfare.*

identifies poor work or omissions. Dictionary definition: SNAG - an unexpected or hidden obstacle or drawback.

... talking wastes time when there are other pressing things to do.

Beth, a Primary Nurse in a Ward Manager, role tells me of her experience of silence:

I will give opinions at meetings, but management has always got a way of twisting things round, that you will have to do it. Colleagues I think sometimes they're quiet because they're thinking, oh we've been down this route before, keep your mouth shut because it'll go away. Some of the issues that have come up we've heard it before, nothings been done about it (Interview: Ward Manager Beth).

The irony being that the silence was broken after the management meetings, during walking back to the wards Senior RNs chatted, one example being **it's pointless going to meetings because all you get is nothing (fieldnotes)*. A Primary Nurse's experience of silence in meetings was:

a lot of people at my level go to a meeting and are silent, we just sit and listen, probably because we feel they'll listen but again nothing will be done about it. Even if we've got some good ideas for change they'll [managers] probably sit there saying oh yes, oh yes I'll get in touch and nothing will be done about it. So you just sit there (Interview: Primary Nurse Tina).

Another Primary Nurse promoted during fieldwork to Ward Manager explains how she tries to avoid attending management meetings:

I only go [to management meetings] if I can't avoid it, if they tell me I've got to go. We went to a meeting a few weeks ago about the Primary Nurse development programme and I was the only person who said anything, apart from the [Head Nurse] the whole meeting, and yet as soon as we got out they started moaning. I mean if you're gonna just sit there, what's the point of being there you can read the minutes (Interview: Ward Manager Grace).

The 'forum for nursing silence', extends beyond management meetings to the surgical wards. It is particularly evident during the medical ward round where Junior RNs show signs of running scared, despite the ward co-ordinator encouraging them to come to the notes trolley and contribute about their patients. More often than not the Juniors go missing, a form of avoidance behaviour as a Primary Nurse illustrates:

I don't know if they're scared of the Doctors or scared of making a fool of themselves because they haven't got the knowledge, or whether they see it as our role, they just step back, they're sort of there but not, they're scared of responsibility and accountability (Interview: Primary Nurse Tina).

The opportunity to break the silence about Nursing manifests itself during the ethnographic interviews, which seem to provide a forum for RNs to reflect on what seems to be a 'silence of oppression', across the Surgical Directorate. A Junior RN undertaking her degree shed some light on this:

it's nice to talk about nursing and about me. You don't get a chance, you just do not get a chance, I never sit down on the ward ... this is nice, I've just sat in here, in the interview thinking, talking, thinking, it's nice to come away, it's nice to get away and talk... it's nice. I think that's why when we talk about nursing in class ... that's why so many people start talking ... I've noticed, everybody starts talking and it's nice because you don't get to say those things in the ward, nobody's interested in nursing ... (Interview: Junior RN promoted to an Associate Nurse Amanda).

On the day after interviewing Grace she saw me in the corridor and told me:

... the interview wasn't too bad, in fact it was nice to talk about my role as you don't often get an opportunity to do this. Nobody talks about nursing, nursing issues anymore, this is the forgotten topic (Fieldnotes: Ward Manager Grace).

The culture of silence is being passed on to the next generation of RNs in the surgical wards as an Associate Nurse describes the lack of talking about nursing:

... nobody talks about nursing, and I think that's because would management listen anyway. I think they [the nurses] have been that shouted down so often and nursing is seen now very much as basic. All the management issues are important, and nursing, patient care just seems to be at the bottom of the list at the moment (Interview: Associate Nurse Sophie).

A Primary Nurse recently awarded her nursing degree raised the issue of silence regarding 'nursing' in the new RN recruits, when asked do you ever talk about nursing ?

there's certain people on the ward you'd do that with, I mean I try to do it, but I think it sounds really terrible, but the junior nurses that we've got, they just don't want to know, they want to come and earn their money and they want to go home, they don't want to know about Nursing models, Care planning ... no they don't want to know, and I really try with the students, I really try and say this is what it's [nursing] about, this is what nursing is, nurses have special skills that doctors don't have, and can never have, and nurses have special skills, and are absolutely brilliant at them and that's what we need to encourage, to encourage that and I've tried to encourage that through the essence of care document, that's been a catalyst for the discussion (Interview: Primary Nurse Denise).

Seniors' overall perspective is that they have no one to talk to about Nursing, and they do not want to be seen as rocking the boat, hence they have created a culture of coping underlined by a silencing of nurses, one where they do not want to be seen as troublemakers:

I think perhaps some people are afraid of rocking the boat or afraid of being seen as troublemakers that's the only reason I can think of, sit quietly and agree with it (Interview: Ward Manager Grace).

the overall ethos is summed up by a Ward Manager:

if they have delivered care with only five staff and there are no complaints and no evidence of poor care, then management are happy (Interview: Ward Manager Lucy).

Conclusion Chapter 7.

When the Surgical RNs thought they had got it right, their holy grail was over as a result of implementing 'best nursing practice' in the form of an all graduate Primary Nursing, care organization labour process, the rug started to be pulled from below their strong foundations when the Trust's non-clinical managers began to place a freeze on Senior RN vacancies, initially replacing these with Junior RNs, and more recently with HCAs. Senior RNs were forced to resort to the next best labour process; Team Nursing which created a feeling of 'going backwards'. The management philosophy of cutting study leave has been a high price to pay in the Trust surgical nurse community, as this is a time when the new generalist prepared Adult RNs need most the specialist post-registration clinical courses to enable them to safely practice, unlike their critical care nurse colleagues, employed within the same Division of the Trust. Thus there seems to be a philosophy of 'filling over of the cracks' , as opposed to strengthening the foundations in the current NHS Acute Trust sector.

The central tenets of the role of Rodin's surgical RNs during the first five years of the new millennium was the delivery of direct patient care to a group of seven surgical patients as a result of the Primary Nursing labour process being in operation since the 90's, brought into being with the replacement monies when

student nurse training moved from an apprenticeship system into the university. Primary Nursing meant for seven patients, their care was holistically delivered by the same team of staff, continuity of care was achieved, with a Senior / Primary Nurse doing A.P.I.E., simultaneously working as a role model for the next generation of RNs, the supernumery adult branch student nurse. Everyone was happy, the patient benefited from an experienced nurses' care and clinical decision making, students and new recruits benefited from excellence in terms of 1:1 support and supervision. Today the RNs role is as a technician and surveyor of all in their charge, and in the words of one very senior RN:

We used to have the best nursing in the hospital, the Gold standard, Primary Nursing, it's gone to team nursing which is Silver Service sometimes it's a Bronze service because the only way they can get through the work is task allocation (Discussion with the retiring Modern Matron).

Chapter 8: The 21st century role of the Registered Nurse.

This final chapter utilizes the sensitizing concepts shown in Figure 2 (p.22), discerned from Braverman's (1974) degradation of work thesis, to interpret structural changes in relation to nursing which have impacting on the RN labour force and their labour process in the English NHS Acute Trust.

The skilled craftsman RN.

Braverman wrote from the skilled 'craftsman' perspective, whose human labour he viewed as a unique process, because the product of the craftsman's labour already exists in his mind on its commencement¹²⁵. The craftsman's capacity to perform work being the unity of conception and execution, with craftsman labour power being a special category inexchangeable with any other, because it gave him control over the labour process. Within the field of skilled craftsmanship, each craftsman's repository of accumulated knowledge of materials, methods and procedures were left to his discretion, each branch of the craft a social division of labour, and a repository of human technique for the labor process of that branch.

Apprenticeships in the traditional crafts ranged from three to five years, to enable knowledge to be assimilated, dexterity to be gained, and like the professional, the craftsman was required to master a specialty, in which he became the best judge of the management of specific production problems. The outcome of the traditional appreticeship, journeyman and master craftsman structures was for Braverman human culture, which through symbols and speech the craftsman passed on to succeeding generations.

¹²⁵ **Human labour** for Braverman was 'intelligent action', the directing mechanism being the power of conceptual thought.

The starting point for applying Braverman's thesis to Hospital Nursing is the passing of the 1919 Nurses' Act, which created the 'General' Nurse, the SRN, whose craft mastery was care of the adult medically and surgically sick in the District General Hospital (DGH). SRN craft mastery was obtained through a General Nurse apprenticeship, which parallels Braverman's manufacturing craft apprenticeship, as both were production place based, apprentices rotating through the pillars of the craft, during which their examinations in theory and in practice increased in complexity. For the General Nurse, his/her craft labour is the speciality acute adult medical and surgical patient care, his/her production product being; safe care of patients whilst in hospital (do no harm), patient discharge from hospital, or in Henderson's (1955) words 'a peaceful death'.

Following the inception of General Nurse training, the mode of production was through the sub-division of hospital nursing work into tasks, with the lion's share of the labour force being Student Nurse apprentices. This task allocation mode of production meant a division of labour through allocating duties based on task complexity, and apprentice experience. A mode of production which led to SRN work often described as hierarchical, with many referring to hospital nursing as being based on 'tradition', as a result of the continued influence of the medical profession. The power of the medical profession over nursing was structurally reinforced after publication of the Briggs (1972) report, who referred to 'overlapping functions between Nurses and Doctors', a concern to which the MOH responded by issuing a health circular on 'extending role', reinforcing the delegating power of the medical profession over nursing.

Since the early 80's the task allocation labour process was slowly replaced with an holistic approach to the provision of hospital nursing, brought about by RNs adopting the 'nursing process' and their increasing interest in nursing models. Through 'backstage' changes to the nursing labour process by SRNs in hospital wards they slowly gained a grip on their labour process decisions, as they worked

towards achieving autonomy over the production process, despite few SRNs being afforded the opportunity to educate themselves beyond registration¹²⁶.

General Nurse autonomy over their labour process was formally endorsed on inception of the UKCC, which drew to a close 63 years of 'traditional' General Nurse apprenticeships [1919-1982] based on a 'medical curriculum model', as a result of the UKCC issuing a Rules Approval Order, where Rule 18 (1) placed future RGN apprentice preparation on a firm footing of nursing theory and practice. Rule 18(1) changes to student nurse apprenticeships brought with it widespread re-structuring of the nursing production process within hospital training wards¹²⁷, giving General Nurses formal control over the nursing labour process. The English National Board (ENB) then re-structured post-registration education for hospital nurses through introduction of the Framework and Higher Award (ENB 1991), which led to the more widespread availability of education linked to practice, putting in place journeyman to master craftsman structures for hospital speciality based RNs.

On inception of the UKCC, and the four National Boards for nurse education, the SRN was rebranded the RGN and the era of true nursing modernization was formally embarked upon. In Braverman terms the unity of conception and execution had arrived for hospital RGNs; student nurse apprenticeships were based on a nursing foundation, and through the ENB co-ordination of post registration courses RGNs were able to record their 'specialist' qualifications on the UKCC register. Craftsman structures were fully in place for progression from a General Nurse apprenticeship, into the journeyman years, and through additional professional clinical courses RGNs could pursue specialization in a branch of production to become a master craftsman. Structures were now in

¹²⁶ Unless they were in medical specialisms like orthopaedics, ophthalmology, or intensive care, programmes initially developed locally but through the setting up of the JBCNS had imposed on them a national standard and professional recognition.

¹²⁷ through adopting nursing models, the nursing process and a labour process of Team or Primary Nursing.

place for the modernization of General Nursing as a result of the new apprenticeship curriculum and the post-registration career framework.

Simultaneously with the ENB post-registration journeyman to master craftsman developments, the UKCC looked to the future through issuing its strategy for pre-registration preparation (Project 2000), and launched its proposals for post-registration education [PREP] (UKCC 1993) indicating there would be three areas of specialist nursing practice (Figure 14. p.57. Table 5. p.58), although the final PREP standards (UKCC 1994) eliminated the previously proposed specialist practice areas for hospital RNs, replacing these with 'new' community nurse specialist qualifications.

The concept 'new' in the occupational market of Nursing.

For Braverman the beginning of the degradation of craftsman work was the introduction of the concept 'new' in the occupational market, a concept he viewed as having a double meaning. In the first sense 'new' referred to the creation of new occupations, whilst in the second 'new' was presumed as advancement and superiority to the 'old'.

Applying Braverman's concept 'new' to the work of the General Nurse, the starting point is the mid 80's when the Conservative government agreed to the move of initial nurse education into HEIs (Project 2000), replacing 'speciality' RN apprenticeships with HE based programmes, where the future Student Nurse was supernumery to the hospital labour force, and a 'new' root and branch 'generalist', health based curriculum. This structural change brought to a close the three year, speciality apprenticeships which had evolved over 75 years to ensure safe preparation of four groups of RNs for the hospitalized sick (SRN, RSCN, RMN, RNLD). In essence future RN students shared their educational programme in an 18 month Common Foundation Programme (CFP), after which they broke into their speciality 'branch' of production for 18 months, reducing by 50% speciality preparation for hospital practice. Future RNs were dubbed

the 'new knowledgeable doer', and the changes hailed at the time as nursing modernization.

I believe the acceptance by the government of the move of student nurse education into HEIs to be the starting point of the degradation of the work of the RN, the beginning of the post modernization of registered nursing, because government caveated the acceptance of the move of nurse education into HEIs with the nursing profession having to accept a new grade of nursing assistant, the support worker. Thus the promise of a 'new' nurse, the future knowledgeable doer came with an underlying skill substitution agenda.

On implementation of the new HEI prepared P2K curriculum there was a three year period in which nurse training systems were 'double running'. 'Old' style apprenticeships were declining, as the 'new' generalist prepared students increased. Government made available money to replace the hospital student nurse labour force, money that was 'trickled into the system', enabling hospitals to replace student nurses in one of two ways. They could implement the government's 'new support worker', through introducing the NVQ framework, opening the door for some hospitals to 'backfill' with what Braverman referred to as 'detail workers', the purchasing of dissociated elements, the semi- or unskilled Health Care Assistants (HCAs)¹²⁸. Alternatively the money could be spent on the 'gold' or 'silver' nursing labour process of 'Primary or Team Nursing' respectively, through employing additional RNs¹²⁹.

The UKCC also announced discontinuation of preparation for entry to the second level part of the register, the Enrolled Nurses, who in essence were the true, skilled assistant grades. Followed by the UKCC launch of a revised register

¹²⁸ As was revealed when the locality studies were conducted, two of the four Acute Trusts implemented the NVQ system with their replacement monies.

¹²⁹ The third Acute Trust opted for a mixture of RNs and HCAs and implemented team nursing, whilst Rodin, the Acute Trust chosen to conduct fieldwork opted for an all RN replacement process thus they were able to implement the GOLD standard Primary Nursing labour process.

distinguishing 'old' speciality prepared RNs [Part 1] from 'new' generalist prepared Adult RNs [Part 12] shown in Table 3. p.47.

The Thatcher government then introduced the White Paper 'Working for Patients' (Cmnd 555) where District General Hospitals (DGH) became independent Acute Trusts and General Practitioners became fundholders, and the starting point for shifting the balance of power away from provider units (hospitals) to purchasers (HMSO 1989). At the time of implementing the purchaser provider structures Nursing Schools were moving into HEIs and implementing Project 2000, everything went fairly smoothly within the nursing profession, 'old' and 'new' RN's had post-registration journeyman to master craftsman structures in place for 'specialist' education, professional qualifications recordable on the UKCC register. For many 'old' style prepared RGNs the ENB framework and Higher Award enabled them to 'catch up' academically with the new Adult (diplomat) RNs. Thus on both sides of the newly structured NHS (purchaser and provider / hospital and community) were ENB recordable qualifications for RNs, on one side clinical courses for hospital RNs, whilst on the other, the new specialist community nurse programmes.

RNs in the NHS were promised a bright future on two fronts. The UKCC pre- and post-registration education structures were in place for advancement from student nurse to master craftsman, additionally RNs future in the re-structured NHS was set out in the Strategy for Nursing (DOH 1989) shown in Appendix 4, followed by the government's pledge to the Named Nurse (DOH 1991), and the UKCC (1992) Scope of Professional Practice, which replaced the medical delegation model for role extension [HC7722].

Although this bright future was slightly 'tarnished' when the Junior Doctors' Improving Working Lives (IWL) agenda was springboarded into the health care arena as a result of the BMA commissioned time and motion study by the consulting firm Greenhalgh and Company (1994) publishing their findings,

concluding RNs were the next best thing to the Junior Doctor for performing tasks they no longer wished to perform.

Under the John Major administration warning signs then began to come to light regarding the after effects of skill mix changes in hospital wards. Government's response was to issue 'Risk Management' (NHSME 1996) guidance to all NHS wards and NHS managers in which they recommended support, supervision and skill mix be reviewed in hospital wards. Warning signs which paled into insignificance as a result of unrest in the general population regarding the purchaser provider structures, which for many were a step too far regarding change in the NHS, and a factor contributing to New Labour general election landslide.

'New' Labour, new tactics: the scientific management of the NHS.

Now we have re-entry into the market of health care Braverman's concept 'new', in the form of 'New' Labour. After winning the general election, New Labour initially found themselves having to deal with their inherited long NHS waiting lists, and a year-on-year crisis in the provision of NHS critical care beds; after dealing with these they turned to 'modernizing the NHS', in their white paper Modern and Dependable (DOH 1997). New labour, brought with it new tactics regarding production process control in the NHS. Modernization reforms commenced with the NHS Plan (DOH 2000a) followed by National Service Frameworks (NSFs) and the Protocol Based Care agenda, strategies passed off as modernization which are no more than Tayloristic techniques Braverman viewed as being aimed at making the work processes of the craftsmen transparent, to enable management to re-house production process control into their hands.

The underpinning rationale according to Braverman for the use of Scientific Management techniques is because skilled craftsmen have the skills and knowledge for the whole production process, giving them control over that

production process¹³⁰. From a managerial perspective this is an expensive, inefficient mode of production¹³¹, with the skilled craftsman labour force being difficult to control, due to their collective allegiance and autonomy. The sole purpose of managers applying Scientific management approaches according to Braverman is, dissolution of craftsman control over the labour process, a dissolution of their human endeavour, Braverman viewed as a purposeful act.

New Labour was therefore instituting a national strategy of scientific management techniques¹³², to centralize craft process knowledge into the hands of management. Through the Taylor system, management could achieve control of the actual mode of performance of every labour activity¹³³, through taking control of the decisions made in the course of the craftsmans work, leading to a decrease at any given level of production of the need for workers engaged directly in production through reassigning the time-consuming mental functions elsewhere.

The drive for NHS managers to control the Acute Trust patient production process came when New Labour, through the Chief Nurse, launched the 10 key roles for nurses, paving the way for mass up-skilling, included in which was the drive to increase the number of non-medical prescribers. The detailed nuances of the modernization of the NHS and its effects on the RN labour force has been like a jigsaw, pieces being released over time in reports containing clichés like:

¹³⁰ With which comes status and power in relation to the employer.

¹³¹ Due to the time-consuming nature of the mental work

¹³² Government's desire to reduce NHS costs and improve efficiency, being to separate mental from manual work, opening the door for management to decrease at any level of production the need for workers engaged directly in production by reassigning time consuming mental functions elsewhere.

¹³³ Braverman argued Taylorian principles de-skilled the craftsman, leaving him 'helpless, powerless and skill-less, controlled from above by managers and reduced on the shop floor to simple unit of production', a thesis he extended to all forms of craftsmanship. The effect being that craft workers become merely part of a huge assembly line of paper controlled by head office.

- Liberating the talents
- Making a difference
- Hidden talents
- Role re-design
- Modernizing nursing careers
- Outreach
- Essence of care
- Working in new ways
- Improving working lives

For the Acute Trust RN, this piecemeal, piece by piece of the jigsaw approach to modernization has slowly but surely drawn increasing numbers of front line, clinical RNs into developmental work; care pathway development, staff re-grading, appraisal and job mapping, service re-design and project management. With each new initiative 'chalk face', 'master craftsmen', Senior RNs are pulled increasingly further away from their day-to-day work of caring for acutely ill patients on hospital non-critical care wards, in the name of modernization, leaving behind Junior RNs with increasing numbers of assistant grades. Simultaneously the nursing profession continues to grapple with its own internal problems in the form of; 'the fitness for purpose and practice' of new nurses (Duffy 2004) and undetected hospital patient deterioration (NCEPOD 2007).

Since New Labour launched the NHS Plan, and the cascade of reforms dropping out of this, local NHS operational managers have refocused their lens not on 'quality patient care' as RNs are used to, but on target achievement in the name of; 'efficiency and effectiveness', or more recently 'service improvement'. Acute Trusts are increasingly employing consulting firms, who in Braverman's view claim they have management skills to perform job / process mapping, and service / job re-design. I propose these initiatives are creating a rise in management costs weighed off against chalk face clinical nursing costs.

The NHS modernization agenda has brought into employment a large body of non-clinical personnel: Service Improvement Teams [SITs], consulting firms advising and preparing the Acute Trust for Foundation status, audit clerks to

process target and 'quality' data, and various other administration and clerical staff, all of whom are salaried and are supplied with costly 'tools of their trade'. In Braverman's view this is the 'creation of new paper occupations', whose work is part of scientific management, aimed at achieving a reversal of production process control from the 'craftsmen' into the hands of management, with which it bringing into operation a paper replication of production before it assumes physical form, dividing the labour process between two bodies of workers, in one location the physical processes of execution, in the other management.

The purchasing of 'dissociated elements': the detail worker.

Because individuals who allocate labour are the only ones who see labour power in economic terms, managers / economists are interested not in the craftsman's social or human relations, but in price relations, thus when he purchases the work of another man this is done through a contract of employment. Where staff are needed management view the skilled as an expensive and inefficient use of labour¹³⁴, believing there are 'equivalents to' the skilled craftsman¹³⁵. For the manager there evolves economic efficiency through backfilling craftsmen with detail workers, which entered into the NHS labour market in the form of the HCA, Braverman describes as semi- (or un-) skilled employees.

The concept 'semi-skilled' Braverman viewed as devisory, due to the prefix 'semi' referring to half or partly, and a prefix when attached to the noun skill, results in a compound word which leaves an impression of a level of training and ability lying somewhere between skill and a total lack of it (Braverman 1974, p.298). An observation Braverman substantiated from a Department of Labour handbook, where semi-skilled operatives were described as those who:

ordinarily receive only brief on the job training. Usually they are told exactly what to do and how to do it, and their work is supervised closely.

¹³⁴ due to the time-consuming nature of the mental work associated with the craftsman role, additionally his / her autonomy over the production process is viewed as difficult.

¹³⁵ because the master of the labour of others only see labour economically not from technical / mode of labour point of view.

They often repeat the same motions or the same jobs throughout the working day. Semi-skilled workers do not need to invest many years in earning their jobs. The simplest repetitive and routine semi-skilled jobs can be learned in a day and mastered in a few weeks. Even those jobs that require a higher degree of skill, such as truck drivers, can be learned in a few months. At the same time, adaptability - the ability to learn new jobs quickly, including the operations of new machines - is an important qualification for semiskilled workers. New employees starting out in semiskilled jobs are not expected to be highly proficient. After a short training period, however, they must work at a standard, fast, and steady pace. Frequently, good eyesight and good coordination are required (ibid., p.298).

These jobs Braverman viewed as requiring merely ordinary physical characteristics of human beings in a fair state of health, where duties are learned over a period of a day to a few months, and where the worker is told exactly what to do, and how to do it, are supervised closely and repeat the same jobs throughout the working day, although a job advertised as requiring adaptability, attributes Braverman suggests are no more than a definition of unskilled labour¹³⁶.

Braverman indicated the gap between skilled and semi-skilled is a matter of years of training, while the creation of the semi-skilled, against no skill is accomplished in two to twelve weeks, and not a realistic distinction but an artifact of the classifier where there are few jobs classified as 'unskilled' where the training period is zero. Braverman suggesting these 'New' categories made up approximately 25% of workers previously classified as semi-skilled and

¹³⁶ his claim being supported by the work of Woodward:

The oldest and most traditional differentiation between hourly paid workers on British industry is based upon skill; skilled, semi-skilled, and unskilled categories being recognized in the wage structure of most industries, and in the class structure of society. Although it is impossible to define these categories with any degree of precision, the terms are commonly used and understood in industry. It is generally accepted that a skilled worker is a craftsman whose training has been spread over several years and is formally recognized outside an individual firm; a semi skilled worker is one who, during a limited period of training, usually between two and 12 weeks, has acquired the manual dexterity or mechanical knowledge needed for his immediate job, and an unskilled worker is one whose job requires no formal training of any kind (ibid., p.299).

75% of workers previously classified as 'unskilled', creating an illusory upgrading of skills from the statistics, which he suggests few have ventured to challenge.

In such a large service industry as the NHS, the majority costs are the skilled RN labour force, who alongside the medical profession have, until recently, had a monopoly over the Acute Trust patient production process. As previously indicated 'detail workers' were able to be established in some Acute Trusts with the Project 2000 replacement monies, but this was not the case in all hospitals because some chose to implement the Primary and Team Nursing labour process. Hence the need for government's and their local Acute Trust non clinical managers desire to bring in tactics to weaken RNs control of the production process. In Rodin this was achieved through placing a freeze on vacancies, backfilling with 'generalist' prepared RNs and their moves towards putting in place an infrastructure for NVQ support workers, thus changing the nursing skill mix at the same time as increasing the number of patients per Registered Nurse. At a national level backfilling with 'detail workers' was endorsed on launch of the Agenda for Change, which introduced a fourth grade of 'detail worker', the 'Assistant Practitioner', whose introduction to the NHS has yet to be fully realized.

The disillusioned 'old' craftsmen.

NHS managers' implementation of government's efficiency and effectiveness strategies, and their consequent increase in productivity, as seen in Rodin occurred without additional clinical staff, created dissatisfaction for many 'experienced' RNs regarding their role and the conditions of production. Craftsmen dissatisfaction led to what Braverman described as 'labour displacement into fields not yet subjected to modern management principles' (Braverman 1974, p.119). For some, disillusioned, and experienced Acute Trust RNs, these changes were too much to cope with and because the grass was being made to look greener in the new Primary Care led NHS, they were able to move

into Primary Care because of the government strategies to avoid patient admission and even referral to the Acute Trust, new nursing roles have strategically evolved in Primary Care in the form of the Case Manager, the Community Matron, NHS Direct services, Primary Care 'first point of contact services' and with the New GMS contract increasing numbers of Practice Nurses.

The exodus of experienced Acute Trust RNs into Primary Care, meant those remaining were left to cope with rising patient dependency and the increased patient throughput, on a backdrop of management's backfilling Senior RN posts with new generalist prepared RNs or HCAs. Consequently the remaining Senior RNs are increasingly disillusioned, as a result of their original work (*in the Primary Nurse labour process care was provided on an holistic, individualized and continuous basis for their hospitalized patients*), having been simplified to tasks, conceived and controlled elsewhere leading to a degrading effect on their technical capacity as an RN. Braverman suggests Taylor's response to craftsman disillusionment was to give them a higher class of work, better wages and the opportunity of upward mobility, management's response to disillusionment by introducing job enrichment and job enlargement¹³⁷ as seen with the introduction of AfC and the new career framework in the NHS. In the context of Acute Trust ward-based Senior RNs they have through the government's modernization strategies become bogged down with the increasing amounts of administrative duties in the form of: policy application, staff appraisal, sickness / absence management and care pathway / service re-design.

In Rodin the Primary Nursing, 'gold' standard labour process was no longer able to be sustained; the post modern Adult RN in the non critical care surgical ward, in the most extreme scenario, is the only regular RN on duty, therefore forced into the role of 'technician' and 'surveyor' due to 'others' in the ward being semi-

¹³⁷ leaving the dirt handling to 'others'.

or un-skilled assistants, un-regulated health carers brought into being as a result of management's desire to cheapen health care labour costs. The RN who was once a Primary Nurse, an holistic carer for the acutely ill surgical patients has in their eyes been downgraded, their role has gone backwards from holistic, direct patient carer and supervisor / supporter of trainees to a surveyor of all ward personnel and patients, and a technician administering medications, interpreting clinical observations recorded by 'others' and conducting technical procedures such as venepuncture, cannulation, passing and removing drainage tubes and dealing with unanticipated acute situations, often found in acute wards.

The habituation of 'new' [nursing] personnel.

For Braverman new personnel are now brought into jobs degraded in comparison with the craft processes of before. Because new staff come from outside, they enter a profession / organization unknown to them from previous experience, therefore they take the organization of work as given. A process of socialization Braverman termed 'the habituation of the new to the [...] mode of production' (ibid., pp. 96-104). New Acute Trust personnel include the generalist prepared Adult RNs, and support workers / HCAs. For new Adult RNs in Rodin, 'old' craftsmen recognised their preparation did not equip them with the knowledge and skills for a role in acute surgical wards, so they compensated for the 'generalist' preparation, with the retention strategy (Appendix 33 and the competency training mechanisms Appendix 34). Whilst the Critical Care Division also tried to help compensate for the increasing problems regarding 'undetected patient deterioration' in the form of their extensive in-house training programmes (listed in Figures 57 and 58) and the 'outreach' service.

In the Acute Trust there are further groups of new staff; those recruited into administrative / clerical grades, Junior Doctors who change their role on a six-monthly basis, a constant trickle of 'new' trainee health care practitioners (from

various professions), and HCAs at bands 1-4 of the new NHS AfC grade and pay scale, all of whom take the organization they are entering at face value. For new RNs this means they see their role as technicians and surveyors, a stark contrast, a culture shock following their university prepared registration. Hence recently dubbed 'too posh to wash' (O'Connor 2007).

The final government act: re-classification of 'nursing' roles.

For Braverman the degrading of skilled work was legitimised through government re-classification of occupations, who for the greater proportion of the working population are those backfilled into roles previously occupied by craftsmen. A labour force whose training is devoid of content, skill and scientific knowledge, because they are assigned to unchanging operations. Braverman viewed the concept skill as being degraded¹³⁸, because the yardstick by which skill was measured shrinks to the point where a worker is considered to possess a 'skill' if a job requires a few days, weeks, or several months training. With jobs requiring six months to a one year learning period, inspiring a paroxysm of awe (ibid., p.307), compared with traditional craft apprenticeships which rarely lasted less than four years but not uncommonly seven years, with Braverman indicating one craftsman could orchestrate 50 detail workers.

The GNC created the State Registered Nurse (SRN), and was in existence for 65 years until its replacement with the UKCC which brought together all the professional bodies and launched a new 11 part register . Here the SRN became the Part 1 RGN, essentially the same as the SRN. Changes to the preparation of future nurses brought about by introduction of Project 2000 led to the Adult Nurse, with a more diverse preparation, which is health-based with clinical experience spanning hospital, community, independent and voluntary sectors. In the UK re-classification of nursing commenced in 2002, as a result of inception

¹³⁸ with which came the degradation of labour.

of a new regulatory body for nursing and midwifery, the NMC. The new NMC register resulted in a merger of 'old' RGNs and 'new' Adult RNs, then on the stroke of midnight, and on the pressing of a computer button, 85 years of hospital nurse structures were wiped out, previously recordable hospital RN specialist (ENB) professional qualifications were de-recorded. On the press of the same button, some Primary Care RNs had their UKCC recorded qualifications gravitated across to the new NMC register as Specialist Practitioners. Table 25 charts the demise of the General Nurse for the sick.

The final government act came with launch of New Labour Agenda for Change (AfC), a modernized career structure and pay system, a nine level framework comprises four levels [1-4] of currently un-regulated personnel, including one additional stratum [Band 4 practitioners], and five levels [5-9] of professional grades. In Braverman's terms these recent changes alongside the introduction of the CF levels constitute a re-classification of nursing.

A key observation emanating from this research is the fact there are no national standards regarding the ratio of AfC professional grades (5-9) to AfC assistant grades (1-4), in Braverman terms this is the ratio between the Skilled, Semi-skilled and unskilled staff, an anomaly in 'nursing establishments' for acute non-critical care wards seen in Rodin. Rodin's in-patient non-critical care wards had 28 beds, due to there being NO defined RN to surgical patient ratios and NO defined ratio of RN (skilled) to HCAs (Levels 1-4) the ratio was observed to range dramatically, earlier described as the Gold, Silver and Bronze nursing labour process:

- 1 RN to 7 patients [1:7] The 'Gold Service' Primary Nursing labour process for acutely ill hospitalised surgical patients.
- 1 RN to 14 patients [1:14] The 'Silver Service' Team Nursing labour process for acutely ill hospitalised surgical patients.
- 1 RN to 28 patients [1:28] 'Bronze Service' Task Allocation labour process for acutely ill hospitalised surgical patients.

Table 25: Professional registration: Occupational re-classification.

| GNC (1919) Register | UKCC (1984) Register | UKCC (1994) Register | NMC (2004) Register | | |
|---|--|--|--|------|----------|
| | | | <u>NURSES</u> | | Sub Part |
| General Nurse (SRN) | RGN | 1. 1 st level Nurse (old) | Adult | RN1 | 1 |
| GNC: Supplementary Register. | EN: General | 2. 2 nd level General | Adult | RN2 | 2 |
| Male Nurse Mental Nurse Mental Defectives Sick Childrens Fever Enrolled Nurse: | RMN | 3. 1 st level Mental illness (old) | Mental Health | RN3 | 1 |
| | EN: Mental | 4. 2 nd level Mental illness | Mental Health | RN4 | 2 |
| | RN: Mental Handicap | 5. 1 st level mental handicap. | Learning disabilities | RN5 | 1 |
| | EN: Mental Handicap | 6. 2 nd level mental handicap. | Learning disabilities | RN6 | 2 |
| | Registered Sick Childrens nurse (RSCN) | 7. 2 nd level Scotland and Northern Ireland | General | RN7 | 2 |
| | RGN: Fever Nurse | 8. RSCN (old) | Children | RN8 | 1 |
| OTHERS | EN: Scotland and Northern Ireland | 9. Fever Nurse | Fever | RN9 | 2 |
| Midwife HV DN OH School Nurse | Midwife | 10. Midwife | <u>Midwives.</u> | MW | |
| | | | <u>Specialist Community Public Health.</u> | | |
| | Health Visitor | 11. Health Visitor | Health Visitor | RHV | |
| | | 12. *Adult Nurse (New) | School nurse | RSN | |
| | | 13. *Mental Nurse (New) | Occupational Health | ROH | |
| | | 14. *Mental Handicap Nurse (New) | Family Health | RFHN | |
| | | 15. *Childrens Nurse (New) | | | |

- Project 2000 prepared Nurses.

A nursing establishment anomaly unearthed as a result of conducting this empirical research, which has not gone unnoticed in much literature in the public domain (Arthur and James 1994, Audit Commission 2001; Buchan and Calman 2004; Crossan and Ferguson 2005; ICN 2004; RCN 2006), begging answers to several questions raised from conducting this study:

- what ratio of RNs to Assistants in non-critical care Acute Trust wards is a safe ratio ?
- what is 'best practice' preparation for these new Assistant grades in non-critical care Acute Trust wards ?

the latter question is raised because the preparation of 'assistant' grades is currently marked by diversity rather than consensus.

Aah but: the unintended consequences of 'skill' substitution.

For the skilled craftsman RN, the speed at which there has been implementation of scientific management techniques into the 21st century NHS, has been unprecedented since launch of the NHS Plan, which has resulted in backfilling 'nursing' posts with detail workers, and de-skilling of RNs through centralizing craft process knowledge in the hands of management, whereby RNs are implementing 'tick the box' pathways of care, which are fine for the well, elective surgical patient, but Acute Trust hospital non-critical care wards house many emergency and major surgical patients who do not neatly follow a pre-planned pathway of care.

Braverman viewed the systematic destruction of 'all around' craftsman skill occurred through bringing into existence skills and occupations corresponding to the need for labour power of purchasers, which over several generations results in standards becoming altered and the meaning of skill degraded, as a result of the craftsman's previous role being broken into fragments, partially re-assembled and their work redistributed to detail workers. For the manager this leads to the purchasing of dissociated elements of the work process, and a

cheapening of the labour process through a sequential process of erosion relentlessly extended to new areas of production. For Braverman backfilling resulted in the 'ah but' phenomena, 'unintended consequences, what Braverman described as the obverse side of purchasing an undefined quality and quantity of [semi- and un-skilled], so-called equivalents to previous skilled craftsmen.

The concepts 'unintended consequences' and 'altered standards' can plausibly be applied to the work of non critical care Acute Trust RNs and their patients, as there is increasing concern regarding hospital patient outcomes and basic care, raised by professionals and consumers. Front line NHS hospital care has been criticized by patients' relatives and friends in relation to the lack of quality basic care; hygiene, information and patient dignity, a situation drawn to the masses' attention through the BBC Undercover nurse documentary (Panorama 2005), in numerous newspapers, for example Street-Porter's (2006) account of her sister's last days of life, and endorsed in the government's patient experience survey, the government original response being the Essence of Care benchmarks patients should expect¹³⁹.

Increasingly hospital patient care is being scrutinized through attempts to correlate ward staffing and patient outcomes (Aiken et al., 2003; Bown et al 2004; Currie et al. 2005; Lankshear, Sheldon and Maynard 2005), these are still evolving. One study into patient outcomes published in the New England Journal of Medicine (2002) concluded RN staffing made the biggest impact on patient outcome, raising a new construct in health care, and an inhumane consequence of skill substitution in the Acute Trust NHS, that of 'Failure to rescue'. Failure to rescue is a new construct, which evolved in America, which refers specifically to the ability to save patients once complications have arisen, an indicator of the

¹³⁹ As an experienced RN I cannot understand why there was a need for such basic elements of nursing practice to be spelt out, and audited, without government first asking why is care not improving when there have been record amounts of investment in hospitals since New Labour came into power?

quality of care in hospitals (McKee, Cole and James 1999), as yet it has not gravitated into British health care literature.

Work Intensification is also an 'aah but' consequence for RNs. When the master engages a labourer through a contract of employment, he purchases a labourer's ability for conception and execution, and thus the useful effects of the human endeavour, through setting it to work. Because human labour is capable of a vast range of productive activities, Braverman points out in reality it means the mere prolongation of working time, to increase the output of the labour process he has purchased. Work intensification was seen in Rodin through the theme 'extending the working week', and the construct 'doing more for more with less', which Ackroyd and Bolton (1999) and Mather, Worrall and Seifert (2005) indicate are increasingly prevalent features of NHS / Public Sector employee lives.

Conclusion Part IV: 'Triple' substitution.

Braverman's view was that the transformation of working humanity into a labour force, a factor of production, was incessant and unending through a process of sequential erosion, consequently pressure on the craftsman was unceasing, as was found in the Rodin's surgical milieu. Government's, and their Acute Trust operational managers', desire to cheapen the nursing labour process, has resulted in the chalk face RN's role being re-designed through several mechanisms:

- Modernization of the NHS through shifting the balance of power to Primary Care.
- A target driven NHS - increasing patient throughput, decreasing length of stay, increasing provision of elective surgery in the private and independent sector, resulting in hospitals dealing with more dependent, more major elective and emergency surgical patients.
- The perpetuation of protocol base care, under the umbrella 'managed care, pulling senior RNs into paper activities.

- Creation of the 'new' support workers (AfC bands 1-4), and sequential erosion of RNs backfilled with 'support workers'.

The overall view from an 'old' style prepared SRN is that the Acute Trust RN is sandwiched between the power of the government and the power of the medical profession, non critical care employed RNs (in surgical wards) are 'sandwiched between' medical and management agendas regarding skill substitution. The medical agenda has come from Junior Doctors' lengthy drive for an Improvement in their Working Lives (IWL), to rid themselves of tasks they feel they should no longer perform. The management agenda has been to operationalize a second form of 'skill substitution', that of replacing RNs with assistant grades.

This 'Double substitution' (Junior Doctor tasks to RN, RN basic care to HCAs) has in essence been accepted by the nursing profession, mainly as a result of its slow evolution. Although this is now being commented on by some eminent RNs, for example McKenna (2007a; 2007b) discusses 'role drift' to exemplify his own concerns as to patient safety of the slow and often somewhat unnoticed movement of what was once nursing work to HCAs. Whilst Shields and Watson (2007) go further by suggesting 'nursing is in a dire situation' (p.70):

Medicine without nursing is an untenable concept: doctors could not practice without highly educated, knowledgeable and competent nurses as part of the health care team. In the UK, nursing is under threat and could pass away, to be replaced by technicians, minimally educated health care assistants and unqualified health workers. Under the influence of pecuniary motives within the NHS, nursing as a role in health care is changing to encompass boundaries which have never been a part of a true nursing role before (p.70).

In the name of modernization there has been a third form of substitution affecting Registered Nursing practice which can be traced back to the inception of Project 2000, substitution of speciality prepared 'General' Nurse training with generalist prepared Adult RNs, employed in Acute Trust non-critical care wards following registration, which house an ever-increasing number of very sick and highly dependent patients, on a backdrop of a declining number of

experienced, speciality prepared RNs and no infrastructure for them to be supported to pursue specialist clinical courses. There seems to be an oversight by the NMC with regard to specifying what are the Pillars of Knowledge and skill for practice in the Acute hospital sector since the demise of the ENB, and comparable with community specialist practitioners. In the USA Acute Care RNs are well supported through the American Medical Surgical Nursing Association (AMSN) national programme of RN preparation for those choosing a career in Adult Medical and Surgical arenas.

With regard to staffing hospital wards the RCN (2006a) have continued to raise concerns that RN to HCA ratios are based on tradition, not taking into account increased patient acuity and patient throughput (ibid., p.5), asking for this to be formally recognised, going so far as to set their own guidance on what they consider safe hospital ward staffing levels. RNs are not the only NHS non-medical health professional labour force to be affected by managers' modernization of skill mix, culminating in the RCN collaborating with other professional organisations¹⁴⁰ to publish guidance on supervision, accountability and delegation of activities to support workers by Registered Practitioners (RCN 2006b), although regulation does not necessarily mean Trust managers will review the ratio of RNs to RN 'assistant' grades.

Appendix 36 draws together a disparate body of UK and USA literature related to discussion and debate on the nursing labour process, reviewed during construction of the thesis, but not included in the main body due to fear of exceeding the word limit. Three themes are used to structure the debate: The rise and demise of the Primary Nursing labour process; Nursing as craft (or as profession) and Re-modernization of nursing or New Public Management (NPM) control of nursing, each providing signposts aimed at expanding points raised in this thesis.

Conclusion to the thesis.

Following formal withdrawal from the fieldwork site my continued role as a Senior Lecturer in the School of Health enabled the maintenance of links with The Rodin Acute Trust, and interaction with some RNs still in employment within the Surgical Directorate, and others who during and following fieldwork displaced into Primary Care, who are now re-training to become Advanced Nurse Practitioners in new 'drop-in centres' and Case Manager roles. My privileged academic position, alongside a somewhat obsessive daily survey of Rodingham's local evening and weekly free newspapers has meant I have been able to continue data collection regarding changes in the Acute Trust and the RN role.

This additional, post-fieldwork data was recorded in a daily journal comprising fieldnotes, memorandum and newspaper cuttings, a data collection strategy Mandelstram (2007) employed in the preparation of his recent text on NHS change. The post-fieldwork journals were subjected to a final analysis which revealed shop floor Acute Trust RNs have been subjected to further modernization / scientific management developments:

- A revising of RN job descriptions.
- Trustwide Nursing skill mix review.
- RNs under AfC who received a band 6 or band 7 were required to re-apply for their jobs.
- Unsuccessful applicants placed on the bank and required to work 'anywhere needed'.
- Downgrading of many RN band 6 and band 7 posts.
- Voluntary and compulsory RN redundancies.
- Re-organization of Modern Matron posts: 12 positions reduced to 8.
- Degas, the 28 bed surgical assessment ward closed, emergency surgical admissions now admitted to a 48 bed assessment unit.
- Specialist RNs [CNS and ANP] required to participate in time and motion studies through filling out of an hour-by-hour electronic diary.
- Increased NVQ training .
- Employment of Band 7 non-nurse practitioners.

¹⁴⁰ RCSLT (Royal College of Speech and Language Therapists), BDA (British Diabetic Association), CSP (The Chartered Society of Physiotherapists), Trent RDSU University of Sheffield.

These findings lead me to ask the question, is what is reported in this thesis the 'start of something', 'the tip of the iceberg' regarding NHS modernization and its consequent effects on the skilled RN in the Acute Trust ?

Contribution to knowledge.

My thesis originally started to take shape in my mind following launch of the UKCC (1992) Scope of Professional Practice guidelines, the turning point for RNs from medical delegation of extended role activities to accountability for role expansion; during this transition I undertook two joint appointment roles strategically developing the role of the RN in line with the 'scope' six principles (shown in Figure 9, p.47). In a more recent role within the University, surgical / non-critical care RNs alerted me to their work having become increasingly problematic, which led me to embark on this research because the historical turning points affecting / shaping 21st century RN practice were not clear.

From the literature I found conflicting views on RN role expansion, role development and role extension, and identified that an analysis of the process of occupational change in relation to the RN in the English Acute Trust hospital had not been presented in print. In the literature I could not reconcile these views, therefore I embarked on the research to shed light on the current conditions of work of the RN in the surgical environment of the Acute Trust, a research endeavour guided by the five questions posed in the introduction to this thesis (pp. 18-19) which I hope have been vividly and faithfully reported in the preceeding pages.

My contribution to the academic community on submitting this thesis is:

- An ethnography at home - rare in nursing due to the time-consuming nature of this form of methodology.
- A thesis grounded in empirical data in both Part I and Part III, auditable if someone needs to verify both the process and product of this research journey (documents available for auditing are outlined in Appendix 37).

- New conceptual constructs for debate within nursing:
 - Working to full capacity: Through 'doing more for more with less'.
 - Boundary disputes.
 - Triple substitution.
- The discerning from Braverman's (1974) *Labour and Monopoly Capitalism* seminal text a set of sensitizing concepts, and their use for interpreting the data in Part IV of the thesis.

From this ethnographic study it can be seen surgical RNs in Rodin have developed, expanded and extended their role to accommodate changes and developments in the surgical arena of the NHS, but at whose expense? The substitution of the 'General' for 'Adult' RN has led to the RN 'surveillance culture'. The standards-minded, accountable culture, bred into those now Senior surgical RNs has led them to invoke mechanisms to develop the next generation of RNs for employment in non-critical care surgical wards, aimed at filling the shortcomings in the new curriculum. Mechanisms which are not valued or recognised by management, as their concern is to get through the modernization demands within existing resources. The effects of extending the working week combined with the generally poor working conditions is a constant battle to recruit and retain staff, for every junior / senior surgical nurse lost from the Trust, the battle for those remaining gets more intense. The final straw was AfC, the compartmentalisation of the nursing workforce, up-killing, de-skilling and role overqualification as seen from downgrading many RNs in Rodin, even though they have the skills, abilities and qualifications.

This backdrop begs the question whose lives are improving in the surgical milieu? Improving working lives (IWL) is an agenda emanating from New Labour. I have taken the liberty of changing slightly the New Labour cliché IWL, by raising the question whose lives are improving in the acute trust surgical milieu? (patients, RNs, nursing assistants, medical staff or managers)? A question asked on the backdrop of the fact surgery continues to be a 'risky business', and a

dimension of NHS provision where there is increasing evidence of concern regarding the care of surgical patients.

Following my own General apprenticeship (1977-1980) as an RN with 30 years continuous service spent in or linked to NHS and Private sector surgical arenas (and who continues to practise on Acute Trust hospital surgical wards), I have throughout my career championed RN role development, role expansion and role extension as a result of taking opportunities afforded me during the 80's and 90's, when the concept 'new' brought with it hope things would be better for the average RN surgical nurse and the adult surgical patient.

Like Braverman I have never yearned for, or perpetuated the nostalgic experience the past was better, as my own apprenticeship to master craftsman was, like for many Senior 'old' style RNs in this study a convoluted journey, far less straightforward than certificate, diploma, degree and masters structures for RNs seen in today's HEI's. 'New' for myself and many of my peers provided opportunities for advancement of the humanitarian endeavour referred to as the nursing profession, we embraced the 80's and 90's changes. We thought we had 'got it right', our work ethic being 'making a difference', but then followed New Labour's launch of the NHS Plan and the cascade of modernization reforms, which at first promised exciting opportunities for RN's when I commenced this research journey, modernization for all intents and purposes is in the author's view the re-modernization nursing era, although you must draw your own conclusions as to the trajectory that has been created following the NHS Plan, and as presented in this thesis.

I have no problem with New Labour viewing the Acute Trust as not necessarily being the best environment for the provision of some NHS Adult patient health care in England, and support that Primary Care agenda for developing care in the community. But for the most vulnerable in society, those requiring acute care, I do have a problem with the RNs I come into contact constantly telling me of

their disillusionment with their role, and their increasing concern regarding patient outcomes.

A Critical reflection on ethnography as methodology and the 'other' in the research journey.

Through deploying the ethnographic dimensions of prolonged engagement and persistent observation it was possible to reveal front and back stage surgical nurse responses to the modernization agenda in the NHS. On the surface the ethnographic methods revealed those responses seen and talked about, but below that fragile surface were those hidden from view dimensions, Goffman described as the backstage endeavour of the ethnographer. In this study the former responses were interpreted as the intended effects of modernization, whilst the latter, unintended responses brought about by Government and the Junior Doctor modernization agendas and presented as unintended consequences which in Part IV were interpreted using Bravermans' sensitizing concepts regarding the degradation of skilled work, seen in Rodin as the demise of Primary Nursing and the boundary disputes between Junior Doctors and RNs. The ethnographic approach also revealed the staffing illusion on surgical wards. These themes I feel could have only been revealed through adopting the traditional ethnographic approach of 'fieldwork' in this study.

Ethnography is renowned for the quantity of data generated, and the subsequent need for its management, regardless of having been well prepared for this through my pre-fieldwork reading, nothing could have prepared me for the quantity of data generated, and the time-consuming nature of managing this, an unanticipated consequence of this methodological approach. I chose to superimpose onto the ethnographic approach a 'reflexivity model (Glaze 1998), which was applied on a continuous basis through daily journaling, and planned 'reflective periods', during which the focus was on journal content. This 'constant reflection' on data and ethnographic insights has caused an almost constant

introspection, a time-consuming additional dimension to the journey and at times dis-abling for completing the thesis. For me this constant reflexivity has been the dark side of the 'reflexive' approach; time-consuming, questioning of my own thinking; often too much questioning, to the point it disabled me from writing.

A further drawback of the research journey is that of its pursuance on a part-time route. As a full-time academic in an NHS-driven School of Health, where there are increasing demands for MSc programmes for health professionals on which I teach, the School has no 'sabbatical' opportunities for writing up. A positive side of the journey relates to the people I have met, and the friendships developed. Moving outside Nursing (into the social sciences domain) has been a liberating experience, through meeting new people and studying modules in sociological theory, which now inform my teaching in the post-graduate multi-professional arena. If I were entering this journey again I would be more confident to adopt a 'critical ethnography' because the warning signs were there when I proposed this research, that all was not well in the surgical milieu. I even contacted Jim Thomas, a writer on Critical Ethnography, but as an RN I did not have the confidence to pursue, what I then viewed as a 'radical approach'.

Recommendations, 'unfinished business'.

This study revealed RNs in non-critical care wards to be marginalised in the current health care climate in England. Marginality refers to the positions of social groups who see themselves as removed from the normative assumptions and oppressive power structure of mainstream society (Hall, Stevens and Meleis 1994). While being on the margins can suggest a negative experience of alienation, the term is used in academic debate and activist politics to suggest a position of advantage from which the dominant society can be critiqued and disrupted. The idea that RNs are marginalized comes from my fieldwork experience where three features of the theory of marginalized persons was

found in the surgical nurse community: these are silence, Cinderella and surveillance. The questions raised at the beginning of the study have been answered, but the questions raised continue to evolve:

- What staffing arrangements best benefit acute patients in non-critical care surgical wards ?
- What do RNs in non-critical care surgical wards perceive as their working conditions ?

Exciting times are ahead for both RNs and assistant grades as the first decade of the 21st century draws to a close, and a decade which has experienced much local, national and global change. This year registered nursing is 90 years old, a landmark marked by an announcement by the NMC that future RNs are to be an all-graduate profession, like AHPs, a landmark in RN history un-marked by national media coverage.

The door is 'partially' open for RNs to respond to the proposed changes to our future preparation, on a backdrop of this thesis which demonstrated a shift from the RN being an holistic carer of patients admitted to the Acute Trust to RN as a technician and a supervisor, against a backdrop of currently prepared Adult RNs being a 'jack of all trades' and a master of none, un-skilled in acute care delivery and ward management due to their diverse preparation as Adult RNs. There is a need for future educationalists to champion the new all graduate preparation of future RNs, and to up-skill future recruits during their pre-registration curriculum.

I ask myself at the end of this journey: Why did I choose such a 'big' topic as the role of the RN, after a long and tortuous journey the RN I was talking about is the 'General' RN, the RN for the adult medical and surgical patient in the District 'general' hospital. For me at the end of this journey, the term 'general' is misinterpreted in many arenas, a topic for future papers.

References.

- Abel-Smith, B. (1960) *A History of the Nursing Profession*. London: Heinemann.
- Ackroyd, S. and Bolton, S. (1999) It is not Taylorism: Mechanisms of work intensification in the provision of Gynaecological Services in a NHS Hospital. *Work, Employment and Society*, **13**(2), pp.369-378.
- Agar, M.H. (1980) *The professional stranger: An informal introduction to ethnography*. San Diego: Academic Press.
- Aiken, L.H., Clarke, S.P., Cheung, R.B., Sloane, D.M., and Silber, J.H. (2003) Educational levels of hospital nurses and surgical patient morbidity. *Journal of the American Medical Association*, **290**(12), pp.1617-1623.
- Allen, D. (1996) *The shape of General Hospital Nursing. The Division of Labour at work*. Ph.D. Thesis, University of Nottingham.
- Arthur, T. and James, N. (1994) Determining nurse staffing levels: A critical review of the literature. *Journal of Advanced Nursing*, **19**(3), pp.558-565.
- Audit Commission (1991) *The Virtue of Patients: Making the best use of ward nursing resources*. London: Audit Commission.
- Audit Commission (1992) *Lying in wait. The use of medical beds in acute hospitals*. London: Audit Commission.
- Audit Commission (2001) *Ward Staffing. Acute Hospital Portfolio, Review of national findings, No 3*. London: Audit Commission.
- Baillie, L. (1995a) Ethnography and Nursing Research: A critical appraisal. *Nurse Researcher*, **3**(2), pp.5-21.
- Baillie, L. (1995b) The relationship between ethnography and feminist research. *Nurse Researcher*, **3**(2), pp.34-44.
- Baly, M.E. (1980) *Nursing and Social Change*. 2nd ed., London: William Heinemann.
- Beardshaw, V. and Robinson, R. (1990) *New for old ? prospects for nursing in the 1990's. No 8 in a series of research reports on current health care policy*. London: Kings Fund Institute.

- Bellamy-Foster, J. (1998) Introduction to the new edition. *in* Braverman, H. *Labor and Monopoly Capital. The Degradation of Work in the Twentieth Century*. 25th Anniversary ed., New York: Monthly Review Press, pp. ix-xxiv.
- Bendall, E. R. D., and Raybould, E. (1969) *A history of the GNC for England and Wales 1919-1969*. London: H. K. Lewis.
- Berg, D.N., and Smith, K.K. (1988) *The self in social inquiry: researching methods*. Newbury park, California: Sage Publications.
- Bergman, R. (1981) Accountability: Definitions and dimensions. *International Nursing Review*, **28**(2), pp.53-59.
- Bevis, R. (1989) *Curriculum Building in Nursing: A process*. 3rd ed., New York: National League for Nursing.
- Bown, M.J., Norwood, M.G., Loftus, I.M., Spiers, P. and Sayers, R.D. (2004) The Surgical Acute Care Unit [SACU] effects on surgical workload and mortality. *American Journal of Surgery*, **74**, pp.881-884.
- Boyle, J.S. (1994) Styles of ethnography *in* Morse, J.M. (ed) *Critical Issues in qualitative research methods*. London: Sage publications, pp.159-185.
- Brannon, R. L. (1990) The reorganization of the nursing labour process: from team to primary nursing. *International Journal of Health Services*, **20**(3), pp.51-24.
- Bravermann, H. (1974) *Labor and Monopoly Capital. The Degradation of Work in the Twentieth Century*. New York: Monthly Review Press.
- British Journal of Nursing (1935) Government of Nurses without consent. *The British Journal of Nursing [BJN]*. **March**, pp.73-74.
- British Journal of Nursing (1939) The Assistant Nurse. *The British Journal of Nursing [BJN]*. **February**, pp.34 -37.
- British Medical Association (1997) *BMA cohort study of 1995. Medical graduates second report. The Pre-registration year*. London: BMA Health Policy and Economic Research Unit [HPERU].
- Bruni, N. (1995) Reshaping ethnography. Contemporary post positivist possibilities. *Nursing Inquiry*, **2**(1), pp.44-52.
- Buchan, J. (April 2004) *A certain ratio? Minimum staffing ratios in nursing. A report for the Royal College of Nursing*. London: RCN.

Buchan, J. and Calman, L. (2004) *Skill-Mix and policy change in the health workforce: Nurses in advanced roles. Organisation for Economic Co-operation and Development (OECD) Health working papers 17*. France: OECD.

Campbell, J. (1995) Making sense of the technique of venepuncture. *Nursing Times*, **91**(31), pp.46-51.

Campbell, M., Copeland, B. and Tate, B. (1998) Taking the standpoint of people with disabilities in research: Experiences with participation. *Canadian Journal of Rehabilitation*, **12**(2), pp.95-104.

Carney, T. F. (1990) The ladder of analytic abstraction. in Miles, M.B. and Huberman, A.M. (1994) *An expanded sourcebook. Qualitative Data Analysis*. 2nd ed. London: Sage Publications, p.92.

Carr, A. J. (1968) 'When is a nursing auxiliary not a 'nursing' auxiliary', *Nursing Times*, **June 28th**, pp.863-4.

Castledine, G. (1996) Nurses role in peripheral venous cannulation. *British Journal of Nursing*, **5**(20), p.1274.

Challenger (2006) DVD. Directed by Glen Jordan. USA; Boulevard Entertainment. The original cast, starring Karen Allen and Barry Bostwick. Available as commercially published DVD. BLVD00621.

Cockayne, E. (1959) The education of the nurse to meet the needs of tomorrow, *Nursing Mirror*, **May 22nd**, pp.603-604.

Coffey, A. (1999) *The ethnographic self: Fieldwork and the representation of identity*. London: Sage Publications.

Cole, A. and Davidson, L. (1992) The Named Nurse: Let's name names. *Nursing Times*, **88**(11), pp.24-27.

Coombs, M. and Dillon, A. (2002) Crossing Boundaries, redefining care: the role of the critical care outreach team. *Journal of Clinical Nursing*, **11**(3), pp.387-393.

Council of Deans (1998) *Breaking the boundaries: Educating Nurses, Midwives and Health Visitors for the next millenium, a position paper*. Manchester: Council of Deans and Heads of UK Unversity faculties for Nurses, Midwives and Health Visitors. www.counciloofdeans.org.uk accessed June 2007.

Council of Deans (2006) **September meeting minutes** Manchester: Council of Deans and Heads of UK University faculties for Nurses, Midwives and Health Visitors. www.councilofdeans.org.uk accessed June 2007.

Council of Deans (2007) *Briefing on the funding and commissioning of Nursing, Midwifery and Allied Health Professionals education in England*. Manchester: Council of Deans and Heads of UK University faculties for Nurses, Midwives and Health Visitors. www.councilofdeans.org.uk accessed January 2008.

Courtney, Z. P. (1978) Training for the job. *Nursing Times*, **January 26th**, pp. 164-165.

Creswell, J. W. (1998) *Qualitative inquiry and research design: Choosing among five traditions*. London: Sage Publications.

Crossan, F. and Ferguson, D, (2005) Exploring Nursing Skill Mix: A review. *Journal of Nursing Management*, **13**(4), pp.356-362.

Crotty, M., Reed, S., Cooper, F. and Foster, H. (1993) Perceived value of the ENB Framework. *Senior Nurse*, **13**(4), pp.47-50.

Currie, V., Harvey, G., West, E., McKenna, H. and Keeney, S. (2005) Relationship between quality of care, staffing levels, skill mix and nurse autonomy: Literature review. *Journal of Advanced Nursing*, **51**(1), pp.73-82.

Davies, K. (1979) The Law of Property in Land, *The Estates Gazette*. **May**, pp. 18-19.

Denzin, N.K. and Lincoln, Y. (1994) *Handbook of Qualitative Research*. London: Sage publications.

Department of Health and Social Services (1971) *The state of the public health. Report of the CMO on the state of public health for 1970*. London: HMSO.

Department of Health and Social Services (1977) *The extending role of the clinical nurse: Legal implications and training requirements. CMO 10/9. Letter accompanying HC/77/22*. London: HMSO.

Department of Health and Social Services (1977) *The Extended Role of the Clinical Nurse, HC(77)22*. London: HMSO.

Department of Health and Social Services (1989a) *The Extending Role of the Nurse. PL/CNO/89/10. DHSS Circular*. London: HMSO.

Department of Health and Social Services (1989b) *Caring for people*. London: HMSO.

Department of Health (1989) *A strategy for nursing. A report of the steering committee*. London: DOH Nursing Division.

Department of Health (1990) *Working for Patients. Cmnd.555*, London: HMSO.

Department of Health (1991) *The Patients Charter: Raising the Standard*. London: DOH.

Department of Health (1992) *The extended role of the nurse / Scope of professional practice. PL/CNO (92) 4*. London: DOH.

Department of Health (1993) *Hospital Doctors training for the future*. London: DOH (Calman Report).

Department of Health (1993a) *Vision for the future. Report of the Chief Nursing Officer*. London: DOH.

Department of Health (1993b) *The challenges for Nursing and Midwifery in the 21st century*. London: DOH (The Heathrow debate).

Department of Health (1994) *Nursing, Midwifery and Health Visiting Education. A statement of strategic Intent*. London: DOH.

Department of Health (1997) *The new NHS: Modern and dependable: Executive summary. Cmd. 3807*. London: HMSO.

Department of Health (1999) *Making a difference. Strengthening the Nursing, Midwifery and Health Visiting contribution to health and healthcare. The New NHS*. London: HMSO.

Department of Health (2000a) *The NHS Plan. A plan for investment, a plan for reform. Cm. 4818-1*, London: DOH.

Department of Health (2000b) *Comprehensive critical care: a review of adult critical care services*. London: DOH.

Department of Health (2001a) *Implementing the NHS Plan: 10 key roles for nurses*. PL/CNO. London: DOH.

Department of Health (2001b) *The Essence of care: Patient-focused benchmarking for health care practitioners*. London: DOH.

Department of Health (2001c) *Research Governance Framework for Health and Social Care*. London: DOH.

Department of Health (2002a) *Liberating the talents. Helping primary care trusts and nurses to deliver the NHS Plan*. London: DOH.

Department of Health (2002b) *Shifting the balance of power. The next steps*. London: DOH.

Department of Health (2002c) *Developing key roles for nurses and midwives: A guide for Managers. PL CNO (2002) 5*. London: DOH.

Department of Health (2002d) *HR in the NHS Plan. More staff working differently*. London: DOH.

Department of Health (2003b) *Modernising medical careers. The response of the four UK Health Ministers to the consultation on unfinished business: Proposals for reform of the SHO grade*. London: DOH.

Department of Health (2004a) *10 high impact changes for service improvement and delivery. A guide for NHS leaders*. NHS Modernization agency. London: DOH.

Department of Health (2004b) *The NHS Knowledge and skills framework (NHS KSF) and the development review process*. London: DOH.

Department of Health (2007) *Towards a framework for post-registration nursing careers: A national consultation*. London: DOH.

Dingwall, R. and McIntosh, J. (eds.) (1978) *Readings in the Sociology of Nursing*. London: Churchill Livingstone.

Dougherty, L. (1996) Intravenous cannulation. RCN Continuing education series Article 371. *Nursing Standard*, **11**(2), pp.47-54.

Dowling, S., Barratt, S. and West, R. (1995) With nurse practitioners, who needs house officers? *British Medical Journal*, **311**(7000), pp.309-313.

Dowling, S., Martin, R., Skidmore, P., Doyal, L., Cameron, A. and Lloyd, S. (1996) Nurses taking on junior doctors' work: a confusion of accountability. *British Medical Journal*, **312**, pp.1211-1214.

Draper, J. (2002) It's the first scientific evidence: Mens experience of pregnancy confirmation. *Journal of Advanced Nursing*, **39**(6), pp.563-570.

Duffy, K. (2004) *Failing students: A qualitative study of factors that influence the decisions regarding assessment of students' competence in practice*. London: NMC.

Edwards, P. (2007) *The state of the labour process debate after 25 years; some reflections from industrial relations and industrial sociology*. Notes for remarks to plenary panel at the 25th International Labour Process Conference. Amsterdam, April 2007. www.ILPC.org.uk accessed December 2007.

Emerson, R.M., Fretz, R.I. and Shaw, L.L. (2001) Participant Observation and fieldnotes in Atkinson, P. Coffey, A. Delamont, S. Lofland, J. and Lofland, L. *Handbook of ethnography*. London: Sage Publications. pp,

English National Board for Nursing and Midwifery (1989) *Project 2000 - 'A new preparation for practice'. Guidelines and criteria for course development and the formation of collaborative links between approved training institutions within the NHS and centers of higher education*. London: ENB.

English National Board for Nursing and Midwifery (1991) *Framework for Continuing Professional Education for Nurses, Midwives and Health Visitors: A guide to implementation*. London: ENB.

English National Board for Nursing and Midwifery and Department of Health (2001) *Placements in focus. Guidance for education in practice for Health Care Professionals*. London. ENB/DOH.

European Working Time Directive (EWTD)
www.hse.gov.uk/contacts/faqs/workingtimedirective.htm

Fetterman. D.M. (1998) *Ethnography: Step by step*. 2nded., Applied social research methods volume 17. London: Sage publications.

Field, P. A. (1983) Clarifying boundaries regarding the role as ethnographer. in Morse, J.M. and Field, P.A. (1985) *Nursing research a qualitative approach*. London: Croom Helm.

Finlay, T. (2000) The scope of professional practice: A literature review to determine the document's impact on nurses' role. *NT Research*, 5(2), pp.115-125.

Francis, J.R.D. (1976) Supervision and examination of higher degree students, Bulletin of the University of London. in Phillips, E.M. and Pugh, D.S. (1987) *How to get a PhD. A handbook for students and supervisors*. Milton Keynes: Open University Press, pp.3-6.

Gardener, M. G. (1977) The history, philosophy and evaluation of the work of the Joint Board of Clinical Nursing Studies. *Journal of Advanced Nursing*, **2**(6), pp.621-632.

Gaze, H. (1990) A glimpse into the future. *Nursing Times*, **86**(16), pp. 28-30.

General Medical Council (2002a) *Implementing the new doctor*. The education committees informal visits to UK universities October 1998 to April 2001. <http://www.gmc-uk.org/med-ed/itnd.htm> accessed February 2004.

General Medical Council (2002b) *Tomorrows doctors*. London: GMC.

General Nursing Council (1964) *Syllabus and record of practical instruction and experience (General) for admission to the roll of nurses*. London: GNC.

General Nursing Council (1969) *Syllabus of subjects for examination and Record of practical instruction and experience for the Certificate of General Nursing*. London: GNC.

Germain, C. (1993) Ethnography. The Method. in Munhall, P.L. and Oiler, C.J. *Nursing Research a qualitative perspective*. Norwalk. Connecticut: Appleton Century Crofts, pp.237-268.

Germain, C.P. (2001) Ethnography: The method. in Munhall, P.L. *Nursing Research. A qualitative perspective*. 3rd ed.,. Massachusettes: National League for Nursing Press, pp.277-306.

Girvin, J. and Clarke, T. (1988) Training Auxiliaries. *Nursing Times*, **84**(50), p.46.

Glaze, J. (1998) Practising the art of reflection. *Practice Nursing*, **9**(20). pp.15-19.

Glaze, J. (2001) Stages in coming to terms with reflection: Student advanced nurse practitioners perceptions of their reflective journeys. *Journal of Advanced Nursing*, **37**(3), pp.265-272.

Glaze, J. (2002) PhD study and the use of a reflective diary: A dialogue with self. *Reflective Practice*, **3**(2), pp.153-166.

Goodman, J. (1984) Reflection and teacher education. A case study and theoretical analysis. *Interchange*, **15**(3). pp.9-26.

Goold, S.D. (2002) Trust, distrust and trustworthiness: Lessons from the field. *Journal of General Internal Medicine*, **17**(1), pp.1497-1525.

Gray, E.S. (1997) Expanding practice to include IV Cannulation. *Professional Nurse*, **13**(3), pp.181-182.

Greenhalgh and Company (1991) *Using Information in managing the nursing resource. The rainbow pack*. London: Greenhalgh and Company.

Greenhalgh and Company (1994) *The interface between junior doctors and Nurses. A research study for the Department of Health*. London: Greenhalgh and Company.

Grundy, M. (1996) The implications of nurse IV drug administration. *Professional Nurse*, **12**(3), pp.207-212.

Guba, E.G. and Lincoln, Y.S. (1981) *Effective Evaluation*. London: Jossey-Bass.

Guba, E.G. and Lincoln, Y.S. (1989) *Judging the quality of fourth generation evaluation in fourth generation evaluation*. London: Sage.

Hak, T. (1998) 'There are clear delusions'. The production of a factual account. *Human Studies*, **21**(4), pp.419-436.

Hall, C. (1996) Nurse suspended after 'taking out man's appendix'. *Independent, The* (London). January 13th. www.independent.co.uk/news/nurse-suspended-after-taking-out-mans-appendix-1567753.html

Hall, J.M., and Stevens, P.E. (1991) Rigor in feminist research. *Advances in Nursing Science*, **13**(3), pp.16-29.

Hall, J.M., Stevens, P.E., and Meleis, A.F. (1994) Marginalization: A guiding concept for valuing diversity in nursing knowledge development. *Advances in nursing science*, **16**(4), pp.23-41.

Hammersley, M. and Atkinson, P. (1995) *Ethnography: Principles in practice*. 2nd ed., London: Routledge.

Hammersley, M. and Atkinson, P. (1998) *Ethnography: Principles in practice*. 3rd ed., London: Routledge.

Hammick, M. (1997) *Managing the ethical process in research. Key management skills in nursing*. London: Quay Books.

Hancock, C. (1992) The named nurse concept. *Nursing Standard*, **6**(17), pp.16-18.

Hardie, M. and Hockey, L. (1978) *Nursing Auxiliaries in Health Care*. London: Croom Helm.

Harris, M. (1968) *The rise of anthropological theory*. New York: Thomas C Crowell.

Harris, M. (1976) History and significance of the emic/etic distinction. *Annual review of anthropology*, 5(1976), pp.329-350.

Harrison, D. (1988) Nursing Auxillaries: An asset not to be wasted. *Senior Nurse*, 8(3), pp.29-31.

Hawthorne, P. (1987) An aide or a hinderance ? *Nursing Times*, January 7th p. 56.

Heath, J. and Law, G.M. (1982) *Nursing Process What is it?: A practical introduction*. Sheffield: NHS Learning Resources Unit.

Henderson, V. (1979) *Basic Principles of Nursing Care*. Geneva. Switzerland: International Council of Nurses. 11th printing, originally published 1960.

Hinds, P.S., Chaves, D.E., and Cypress, S.M. (1992) Context as a source of meaning and understanding. *Qualitative Health Research*, 2(1), pp.61-74.

HMSO (1939) *Inter-departmental Committee on Nursing Service interim report*. London: HMSO (Athlone Committee).

HMSO (1963) *Report of the committee on Senior Nursing Staff structure*: London: HMSO (Salmon Report).

HMSO (1964) *A reform of Nursing Education*. London: HMSO Platt Report.

HMSO (1972) *Report of the committee on Nursing*. Cmnd. 5115. London: HMSO Briggs Report.

HMSO (1989) *Working for patients*. Cm.555. London: HMSO.

HMSO (1991) *National audit office review of NHS out patient department services*. London: HMSO.

Holland, C. K. (1993) An ethnographic study of nursing culture as an exploration for determining the existence of a system of ritual. *Journal of Advanced Nursing*, 18(9), pp.1461-1470.

Holloway, I. and Fulbrook, P. (2001) Revisiting qualitative inquiry. Interviewing in Nursing and midwifery research. *NT Research*, 6(1), pp.539-551.

Holloway, I. and Wheeler, S. (2002) *Qualitative research in nursing*. 2nd ed., Oxford: Blackwell Science.

House, E. R. (1990) An ethics of qualitative field studies. in Guba, E.G. (ed) *The Paradigm Dialog*. Newbury Park, CA: Sage, pp.158-164.

HPERU (2002) *The future healthcare workforce: February 2002*. HPERU discussion paper 9. London: British Medical Association.

Huberman, A.M. and Miles, M.B. (1994) Data Management and Analysis methods. in Denzin, N. and Lincoln, Y. *Handbook of Qualitative Research*. London: Sage publications, pp.428-444.

Hymes, D.H. (1978) What is ethnography ? Sociolinguistic working paper 45. in Carter, K. and Presnell, M. (1994) *Interpretive approaches to interpersonal communication*. New York: State University New York Press.

ICN (2004) **Nurse: Patient Ratios**. ICN factsheet.
http://www.icn.ch/matters_rnpetration-print.htm accessed February 2004.

Inwood, S. (1996) Designing a nurse training programme for venepuncture. *Nursing Standard*, **10**(21), pp.41, 46.

Jackson, A. (1997) Advanced Nursing Practice; performing peripheral intravenous cannulation. *Professional Nurse*, **13**(1), pp.21-23, 25.

Joint Consultants Committee (1996) *Protecting patient safety: Medical procedures performed by non-medically qualified health professionals*. London. BMA House.

Jolley, M. and Darling, V. H. (1982) General Nursing. in Allan, P. and Jolley, M. (eds.) *Nursing, Midwifery and Health Visiting since 1900*. London: Faber and Faber, pp.64-79.

Johnson, M. L. (1978) Nursing auxiliaries and nursing professionalisation. *Nursing Times*, February 23rd, pp.313-317.

Jones, C. and Jack, B. (1999) Dilemmas in the ethics of health-care research. *Professional Nurse*, **14**(7), pp.452-455.

Keeney, S. Hasson, F. McKenna, H. and Gillen, P. (2005) 'Nurses', midwives' and patients' perceptions of trained health care assistants', *Journal of Advanced Nursing*, **50**(4), pp.345-355.

Keywood, O. (1978) Will our auxilliary nurses become assistant nurses ? *Nursing Mirror*, March 16th. p.30.

Kings Fund Institute (1991) *Home and hospital care. Redrawing the boundaries*. London: Kings Fund Institute.

Kings Fund Institute (1992) *From hospital to home, the potential for acute service provision in the home*. London: Kings Fund Institute.

Kirk, J. and Miller, M.L. (1986) *Reliability and validity in qualitative research. Qualitative research methods Series 1*. London: Sage Publications.

Knights, D. and Willmott, H. (1990) *Labour Process Theory*. London: MacMillan Press.

Koch, T. (1994) Establishing rigour in qualitative research: the decision trail, *Journal of Advanced Nursing*, **19**(5), pp.976-986.

Koch, T. and Harrington, A. (1998) Reconceptualising rigour: The case for reflexivity. *Journal of Advanced Nursing*, **28**(4), pp.882-890.

Konick-McMahon, J. (1996) Full speed ahead-with caution: Pushing IV medication. *Nursing*, **26**(6), pp.26-32.

Land, L. Ni Mhaolrunagh, S. and Castledine, G. (1996) Extent and effectiveness of the scope of professional practice. *Nursing Times*, **92**(35), pp.32-35.

Lankshear, A.,J, Sheldon, T.A. and Maynard, A. (2005) Nurse staffing and healthcare outcomes: A systematic review of the international research evidence. *Advances in Nursing Science*, **28**(2), pp.163-174.

Laughern, C. (1995) Ethnography: research method or philosophy?. *Nurse researcher*, **3**(2), pp.45-54.

Laxade, S. and Hale, C. A. (1995) Managed Care 1: An opportunity for nursing. *British Journal of Nursing*, **4**(5), pp.290-294.

LearnDirect (2006) *Health care assistant* <http://learndirect-advice.co.uk> accessed December 2007.

LeCompte, M.D. (1987) Bias in the biography: Bias and subjectivity in ethnographic research. *Anthropology and Education quarterly*, **18**(1), pp.43-52.

LeCompte, M.D. and Schensul, J.J. (1999) *Designing and conducting ethnographic research. Book 1. The ethnographers toolkit*. London: Alta Mira Press. Sage Publications.

Leininger, M. M. (1987) Importance and uses of ethnomethods: Ethnography and ethnonursing research. in Cahoon M.C. (ed.) *Recent Advances in Nursing: Research Methodology* Edinburgh: Churchill Livingstone, pp.12-36.

Leininger, M. (1994) Evaluation criteria and critique of qualitative research studies in Morse, J.N. (ed) *Critical issues in qualitative research methods*. London: Sage Publications, pp.95-115.

Leonard, S. (1999) The expanded role of the nurse: Studying nurses perceptions. *Nursing Standard*, **13**(43), pp.32-36.

Lincoln, Y.S. (1995) Emerging criteria for quality in qualitative and interpretive research. *Qualitative Inquiry*, **1**(3), pp.275-289.

Lincoln, Y.S. and Guba, E.G. (1985) Establishing Trustworthiness. in Lincoln, Y.S. and Guba, E.G. *Naturalistic Inquiry*. London: Sage Publications, pp.289-331.

Littler, C.R. (1982) *The development of the labour process in capitalist societies*. Hampshire. England: Gower Publishing.

Long, T. and Johnson, M. (2000) Rigour, reliability and validity in qualitative research. *Clinical Effectiveness in Nursing*, **4**(1), pp.30-37.

Mackenzie, A. E. (1994) Evaluating ethnography: Considerations for analysis. *Journal of Advanced Nursing*, **19**(4), pp.774-781.

Macleod Clark, J. and Maben, J. (1998) Health Promotion: perceptions of Project 2000 educated nurses. *Health Education Research*, **13**(2), pp.185-196.

Macleod, M. (1996) *Practicing Nursing: Becoming Experienced*. New York: Churchill Livingstone.

Malby, R. (1990) Vocational Support. *Nursing Times*, **86**(16), pp.31-33.

Malinowski, B. (1922) *Argonauts of the western pacific*. New York: Dutton.

Mandelstram, M. (2007) *Betraying the NHS: Health abandoned*. London: Jessica Kingsley publishers.

Mann, T. (1998) *Clinical Guidelines: Using clinical guidelines to improve patient care within the NHS*. Leeds: NHS Executive.

Marshall, C, and Rossman, G.B. (1999) Defending the value and logic of qualitative research. in *Designing qualitative research*. 3rd ed. London: Sage Publications, pp.191-204.

Masson, M. (1985) *A pictorial History of Nursing*. Middlesex: Hamlyn.

Mather, K. Worrall, L. and Seifert, R, (2005) *Work Intensification in the public sector*. University of Wolverhampton Working paper series 2005. www.wlv.ac.uk/uwbs-internal publications WP002/05 accessed December 2007.

McConnell, E. A. (1996) Clinical do's and don't administering IV push injections through an existing peripheral line. *Nursing*, **26**(8), p.24.

McCormack, B. (1992) A case study identifying nursing staffs perceptions of the delivery methods of nursing care in practice on a particular ward. *Journal of Advanced Nursing*, **17**(2), pp.187-197.

McGloin, H., Adam, S. K. and Singer, M. (1999) Unexpected deaths and referrals to intensive care of patients on general wards. Are some cases potentially avoidable? *Journal of the Royal College of Physicians of London*, **33**(3), pp.255-259.

McKee, M. Cole, J. and James, P. (1999) Failure to rescue as a measure of quality of hospital care: The limitations of secondary diagnosis coding in English hospital data. *Journal of Public Health Medicine*, **21**(4), pp.453-458.

McKenna, H. Thompson, D. and Watson, R. (2007a) Health care Assistants - An Oxymoron ?. *International Journal of Nursing Studies*, **44**(8), pp.1283-1284.

McKenna, H. (2007b) 'Role drift' to unlicensed assistants: risks to quality and safety. *Quality and safety in health care*, **13**(6), pp.410-411.

McQuillan, P., Pilkington, S., Allan, A. Taylor, B. Short, A. Morgan, G. Nielson, M. Barratt, D. and Smith, G. (1998) Confidential inquiry into quality of care before admission to intensive care. *British Medical Journal*, **316**(7148), pp. 1853-1858.

Miles, M. B. and Huberman, A. M. (1994) *An expanded sourcebook. Qualitative data analysis*. 2nd ed., London: Sage Publications.

Mishler, E. G. (1979) Meaning in context: Is there any other kind ? *Harvard Educational Review*, **49**(1), pp.1-19.

Modernization Agency (2004) *Findings and recommendations from the hospital at night project*. London: NHS Modernization agency.

MOH (1949) *Circular: RHB(49)156*. London: Ministry of Health.

Moore, D. (1996) *NVQ presentation and paper to Senior Nurses: Russells Hall Hospital*. Dudley. West Midlands. Unpublished.

Morse, J. (1992) *Qualitative Health Research*. London: Sage Publications.

Morse, J.M. (1998) Validity by committee. Editorial. *Qualitative Health Research*, 8(4), pp.552-558.

Muecke, M. A. (1994) On the evaluation of ethnographies. in Morse, J. M. (ed.) *Critical Issues in qualitative research methods*. London: Sage publications, pp.187-209.

National Confidential Enquiry Peri Operative Deaths (2005) *An acute problem ? A report of the national confidential enquiry into patient outcomes and death*. London: NCEPOD.

National Confidential Enquiry Peri Operative Deaths (2007) *Acutely ill patients in hospital*. NICE clinical guideline 60. July 2007. National Institute for Clinical Excellence. London: NCEPOD.

NHS Executive (1998) *Information on clinical effectiveness*. Leeds: NHS Executive.

National Health Service Management Executive (1990) *Junior Doctors Hours*. London. NHSME.

National Health Service Management Executive (1991a) *Day Surgery: Making it happen*. London: Value For Money Unit. NHSME.

National Health Service Management Executive (1991b) *Junior Doctors The New Deal*. London. NHSME.

- | | |
|----------|---|
| Paper 1: | Working arrangements for doctors and dentists in training. |
| Paper 2: | Guidance from the conference of medical royal colleges and their faculties in the UK. |
| Paper 3: | Guidance from the central consultants and specialist committee. |
| Paper 4: | Living and working conditions of doctors in training. |
| Paper 5: | Guidance on regional task forces. |
| Paper 6: | <i>Making the best use of the skills of Nurses and Midwives.</i> |
| Paper 7: | Making better use of technical, administrative, clerical and other support staff and systems. |

National Health Service Management Executive (1996) Chapter 8: Identifying risks arising from working beyond ones competence in *Risk Management*. London: NHSME.

National Health Service Training Authority (1987) *Support workers to Nurses ,Midwives and Health Visitors. The role, selection and training issues*. London: NHSTA.

National Institute for Clinical Excellence (2007) *Acutely ill patients in hospital. NICE clinical guideline 50*. London: NICE.

Nursing and Midwifery Council (2002) *Code of Professional Conduct*. London: NMC.

Nursing and Midwifery Council (2004a) *Standards of proficiency for nurse education*. London: NMC.

Nursing and Midwifery Council (August 2004) *Post registration development. A framework for planning, commissioning and delivering learning beyond registration for Nurses and Midwives*. The report of a task group convened and chaired by the CNO. London: NMC.

Nuffield Provincial Hospitals Trust (1953) *The work of nurses in hospital wards. Report of a job analysis* (Nuffield-Goddard Report). London: Nuffield Provincial Hospitals Trust.

O'dell, M. Forster, A. Rudman, K. and Bass, F. (2002) The critical care outreach service and the early warning system on surgical wards. *Nursing in Critical Care*, 7(3), pp.132-135.

Okely, J. and Callaway, H. (1992) *Anthropology and autobiography*. London: Routledge.

Oxford Health Care Apprenticeship programme (2006) www.oxford-apprenticeship.co.uk accessed January 2007.

Patton, M. Q. (1990) *Qualitative evaluation and research methods*. 2nd ed., Newbury Park California: Sage Publications.

Peysner, J. (1995) The captain on the bridge. Health care risk report. 1. p.8. in McHale, J.V. and Tingle, J. (2001) *Law and Nursing*. London: Butterworth Heinemann.

Pollock, A. M. (2004) *NHS PLC: The Privatization of Our Health Care*. London: Verso.

Royal College of Nursing (1941-1949) *Special reconstitution committee (Horder)*. London: RCN.

Royal College of Nursing (1945) *Education and Training sub committee (Horder)*. London: RCN.

Royal College of Nursing (1978) *The Duties and Position of the Nurse*. London: RCN.

Royal College of Nursing (1979) *The Extended Clinical Role of the Nurse*. London: RCN.

Royal College of Nursing (1992) *The role of the support worker within the professional nursing team*. London: RCN.

Royal College of Nursing (1999) *Look back, move on: Clinical supervision for Nurses*. London: RCN.

Royal College of Nursing (2002a) *Defining Nursing*. London: RCN.

Royal College of Nursing (2002b) *Quality education for quality care*. London: RCN.

Royal College of Nursing (2003) *Future Nurse*. London: RCN.

Royal College of Nursing (2006a) *Setting appropriate ward nurse staffing levels in NHS Acute Trusts*. London: RCN Policy Unit.

Royal College of Nursing (2006b) *Supervision, accountability and delegation of activities to support workers. A guide for registered practitioners and support workers*. Intercollegiate information paper developed by the CSP, RCSLT, BDA and the RCN: London: RCN.

Royal College of Nursing (2007a) *Modernizing nursing careers*. London: RCN.

Royal College of Nursing (2007b) *Modernizing nursing careers*. London: RCN.

Read, S. M. with the ENRip Team (2001) *Exploring new roles in practice (ENRip)*. Final Report. University of Sheffield School of Nursing and Midwifery. England: <http://www.snm.sheaf.ac.uk/research/enrip.pdf>

Resnick, B. (1996) Motivation in geriatric rehabilitation. *Image: The Journal of Nursing Scholarship*, **28**(1), pp.41-45.

Revans, R.W. (1964) *Standards for morale. Cause and effect in hospitals*. London: Open University Press.

Richards, J. (1996) *Two levels of care: The emergence of the health care assistant and the implications for the Registered Nurse*. in Kenrick, Weir and Rosser¹⁴¹ ...

Richardson, G. Maynard, A. Cullum, N. and Kindig, D. (1998) Skill Mix Changes: Substitution or service development? *Health Policy*, **45**(2), pp.119-132.

Rivett, G. (1998) *From cradle to grave. 50 years of the NHS*. London: Kings Fund.

Robertson, M.H.B. and Boyle, J.S. (1984) Ethnography: Contributions to nursing research. *Journal of Advanced Nursing*, **9**(1), pp.43-49.

Robson, C. (1993) *Real World Research*. Oxford: Blackwell Publications.

Roper, J.M. and Shapira, J. (2000) *Ethnography in nursing research*. England: Sage.

Ross, T. (1981) Pride and prejudice. Nursing Auxillaries. *Nursing Mirror*, **153**(25), pp.31-32.

Ryan, G. W. and Russell-Bernard, H. (2000) Data Management and analysis methods in Denzin, N.K. and Lincoln, Y.S. (eds) *Handbook of qualitative research*. 2nd ed., London: Sage, pp.769-802

Salvage, J. (2000) Participative Observation: Standing in the Shoes of Others? *Qualitative Health Research*. **10**(3), pp.324-339.

Sandelowski, M. (1986) The problem of rigor in qualitative research. *Advances in Nursing Science*, **8**(3), pp.27-37.

Sandelowski, M. (1994) Focus on qualitative methods: Notes on transcription. *Research in Nursing and Health*, **17**(4), pp.311-314.

Savishinsky, J. (1993) The institutionalized anthropologist: Hoe ethnography can contribute to an understanding of nursing home culture. Loss, grief and Care: *A Journal of Professional Practice*, **7**(1/2), pp.45-60.

¹⁴¹ unfortunately only a photocopy of chapter 9 from the book is available and after considerable time spent trying to locate the book ... this endeavour was unsuccessful.

Schwandt, T. A. (2001) *Dictionary of qualitative inquiry*. 2nd ed., London: Sage publications.

Scott, H. (1997) Doctors seek to transfer repetitive roles to nurses. *British Journal of Nursing*, **6**(6), p.300.

Seymour, J. (1987) Youth of today, sisters of tomorrow. *The Health Service Journal*, **February 5th**, p.151.

Shields, L. and Watson, R. (2007) The demise of nursing in the United Kingdom: a warning for medicine. *Journal of the Royal Society of Medicine*, **100**(2), pp.70-74.

Skeet, M. (1997) Nursing aides, auxiliaries and assistants. *Nursing Times*, **73**(46), pp.145-148.

Skills for Health (2007) <http://www.skillsforhealth.org.uk/page/career-framework> accessed October 2007.

Slack, P. (1986) Whose helping hand ? *Nursing Times*, **82**(48), pp.32-33.

Slevin, E. and Sines, D. (1999) Enhancing the truthfulness, consistency and transferability of a qualitative study: using a manifold approach. *Nurse researcher*, **7**(2), pp.79-97.

Smith, L. M. (1990) Ethics, field studies and the paradigm crisis in Guba, E. G. (ed.,) *The Paradigm Dialog*. Newbury Park California: Sage, pp.139-157.

Smith, A. and Wood, J. (1998) Can some in hospital cardio-respiratory arrests be prevented ? A prospective survey. *Resuscitation*, **37**(3), pp.133-137.

SNAC/SMAC (1986) *The extending role of the nurse*: Report of a working party set up jointly by the Standing Medical Advisory Committee and the Standing Nursing and Midwifery Advisory Committee. SL/0457b/1. London: MOH.

Scottish Office Department of Health (1995) *Health Service Developments and the Scope of Professional Nursing Practice. A survey of developing clinical roles within NHS Trusts in Scotland*. Edinburgh: National Nursing, Midwifery and Health Visiting Advisory Committee. SODOH.

Sorrell, J. M. and Redmond, G. M. (1995) Interviews in qualitative research: Differing approaches for ethnographic and phenomenological studies. *Journal of Advanced Nursing*, **21**(6), pp.117-122.

Spilsbury, K. and Meyer, J. (2005) Making claims on nursing work. Exploring the work of healthcare assistants and the implications for registered nurses' roles. *Journal of Research in Nursing*, **10**(1), pp.65-83.

Spradley, J. P. (1980) *Participant Observation*. New York: Holt, Rinehart and Winston.

Spradley, J. P. and Mann, B. J. (1975) *The Cocktail Waitress. Work in a mans world*. New York: John Wiley.

Stewart, A. (1998) *The ethnographers method. Qualitative research series 46*. London: Sage Publications.

Still, A.L. (1921) Conference on Nurse Education. *The British Journal of Nursing*, **May 7th**, pp.266-268.

Stokes, J. and Warden, A. (2004) The changing role of the healthcare assistant. *Nursing Standard*, **18**(51), pp.33-37.

Street, A.F. (1992) *Inside Nursing: A critical ethnography of clinical nursing practice*. Albany: State University of New York Press.

Street-Porter, J. (2006) The betrayal of my sister. *Daily Mail*. **November 21st**, pp.37-38, 45.

Thomas, J. (1993) *Doing critical ethnography. Qualitative research methods series 26. A Sage university paper*. London: Sage.

Titmus, R. M. (1968) Commitment to welfare in Baly, M.E. (1980) *Nursing and Social Change*. 2nd ed. London: Heinemann, p.208.

Toffler, A. (1970) *Future Shock*. London: Pan Books.

Townsend, E. (1992) Institutional Ethnography: A method for showing how the context shapes practice. *Human Studies*, **21**(4), pp.347-360.

United Kingdom Central Council (1982) *Rule 18 (1) competencies for first level nurses*. SI 1983 /667. London: UKCC.

United Kingdom Central Council (1983) *Rule 18(2) competencies for second level nurses*. London: UKCC.

United Kingdom Central Council (1985a) *Project 2000 Redrawing the boundaries. Project Paper 5: Education policy advisory Committee*. London: UKCC.

United Kingdom Central Council (1985) *Project 2000 Facing the future. Project Paper 6: Education policy advisory Committee*. London: UKCC.

United Kingdom Central Council (1986) *Project 2000: A new preparation for practice*. London: UKCC.

United Kingdom Central Council (1987a) *The European commission directive (77/453/EEC) Training programme for nurses responsible for general care*. PS&D/87/10/ London: UKCC.

United Kingdom Central Council (1987b) *Educational requirements for entry to training*. PS&D/87/12. London: UKCC.

United Kingdom Central Council (1987c) *Project 2000*. PS&D/87/11. London: UKCC.

Paper 4: The CFP

Paper 5: Widening the entry gate

Paper 6: The enrolled Nurse.

United Kingdom Central Council (1990) *PREP Initial report*. London: UKCC.

United Kingdom Central Council (1992a) *Scope of Professional Practice*. London: UKCC.

United Kingdom Central Council (1992b) *Registrar's letter 15/1992*. The scope of professional practice. June 1992. London: UKCC.

United Kingdom Central Council (1993) *Registra's letter. The councils position concerning a period of support and preceptorship*. January. London: UKCC.

United Kingdom Central Council (1994) *The future of professional practice: The councils standards for education and practice following registration*. Position statement. London: UKCC.

United Kingdom Central Council (1994) *The councils standards for education and practice following registration: Programmes of education leading to the qualification of specialist practitioner*. Registrar's letter 20/1994 December. London: UKCC.

United Kingdom Central Council (1996) *Position statement on clinical supervision for Nursing and Health Visiting*. London: UKCC.

United Kingdom Central Council (1997a) *Scope in practice*. London: UKCC.

United Kingdom Central Council (1997b) *An agenda for action re the Enrolled Nurse*. London: UKCC.

United Kingdom Central Council (1998a) *Standards for specialist community nurses*. London: UKCC.

United Uingdom Central Council (1998b) *Position paper on the development of the support worker role*. London: UKCC.

United Kingdom Central Council (1999) *Fitness for practice. The UKCC commission for nursing and midwifery education (The Peach report)*. London: UKCC.

United Kingdom Central Council (2000a) *The scope of professional practice - a study of its implementation*. London: UKCC.

United Kingdom Central Council (2000b) *Enrolled Nursing-delivering the agenda for action*. London: UKCC.

United Kingdom Central Council (2001) *Fitness for practice and purpose*. London: UKCC.

Vousden, M. (1987a) No experience necessary. *Nursing Times*, **83**(31), pp.16-17.

Vousden, M. (1987b) Open sesame ? *Nursing Times*, **84**(36), p.19.

Wakefield, A.B. (1998) Sign reading: Making sense of what is going on in the ward. *Journal of Clinical Nursing*, **7**(6), pp.499-504.

Werner, O. and Schoepfle, G.M. (1987) Systematic fieldwork, in Stewart, A. (1998) *The Ethnographers Method*. Qualitative research methods series 46. London: Sage Publications.

White, R. (1982) The Nurses Act 1949: Service priorities. *Nursing Times Occasional paper*, **Feb 3rd**, pp.13-15.

White, R. (1985) *The effects of the NHS on the Nursing profession 1948-1961*. Kings Fund Historical Series. 3. London: King Edward Hospital Fund.

Williams, A. (1997) The reality of research: Pitfalls on the road to ethical approval. *Nurse Researcher*, **5**(1), pp.15-22.

Willis, P.E. (1977) *Learning to Labour. How working class kids get working class jobs*. Hants. England: Saxon House.

Willis, P. and Trondman, M, (2000) Manifesto for ethnography. *Ethnography*, 1(1), pp.5-16.

Wolcott, H.F. (1994) *Transforming qualitative data: Description, analysis and interpretation*. Thousand Oaks, CA: Sage Publications.

Wolcott, H.F. (1995) *The art of fieldwork*. London: Alta Mira Press.

Wright, S.G. (1995) The role of the nurse: Extended or expanded, *Nursing Standard*, 9(33), pp.25-29.

Selective Bibliography.

Nurse staffing, patient dependency and patient outcomes (failure to rescue).

Auditor General for Scotland (December 2002) *Planning ward nursing: Legacy or design?*
Auditor General. Scotland. www.audit-scotland.gov.uk

Ball, J.A., Goldstone, and L.A. Collier, M.M. (1984) *Criteria for care. The manual of the north west staffing levels project.* Newcastle: Newcastle upon Tyne Polytechnic Products.

Ball, J.A. and Hurst, K. (1989) *But who will make the beds?* The report of the mersey region project on assessment of nurse staffing and support worker requirements for Acute General Hospitals. Trent: NHS Institute for health service studies and Mersey RHA.

Banham, L. and Connelly, J. (2002) Skill mix, doctors and nurses: Substitution or diversification? *Journal of Management in Medicine*, **16**(4), pp.259-270.

Buchan, J. and Dal Poz, M. R. (2002) Skill Mix in the health care workforce: Reviewing the evidence. *Bulletin of the World Health Organization*, **80**(7), pp.575-580.

Calpin-Davies, P.J. and Akenhurst, R.L. (1990) Doctor-Nurse substitutions: The workforce equation. *Journal of Nurse Management*, **7**(2). pp. 71-79.

Carr-Hill R, Dixon P, Gibbs I, and Griffiths, M. (September 1992) *Skill mix and the effectiveness of nursing care.* England: Centre for Health Economics. University of York.

Department of Health (April 2002) *Ward Staffing Budgets.* PL/CNO/2002/03. London: DOH.

Estabrooks, C.A., Midodzi, W.K, Cummings, G.G, Richter, K, L, and Giovannetti, P, (2005) The impact of hospital nursing characteristics on 30 day mortality. *Nursing Research*, **54**(2), pp.74-84.

Health Grades (May 2005) *Medical-errors gap widens between best and worst hospitals:* Health grades study: Second annual report patient safety in American hospitals.
www.healthgrades.com

Healthcare Commission (2004) *Ward Staffing.* Acute Hospital Portfolio. Guide to topic 2004. London: Healthcare Commission.

Hurst, K. (2002) *Selecting and applying models for estimating the size and mix of nursing teams.* A systematic review. Commissioned by the Department of Health. London: DOH.

International Council of Nursing (2003) *ICN Workforce forum.* Overview paper 29-30 September. www.icn.co

International Council of Nursing (2006) *The global nursing shortage: Priority areas for inbetweenies*. The global nursing review initiative. The Burdett Trust. www.icn.co

Jenkins-Clarke, S. (March 1992) *Measuring Nursing Workload: A cautionary tale*. Discussion paper 96. York: Centre for Health Economics. York University.

McKenna, H. P. (1995) Nursing skill mix substitutions and quality of care: An exploration of assumptions from the research literature. *Journal of Advanced Nursing*, **21**(3) p.452-459.

Needleman, J, and Buerhaus, P, (2002) Nurse staffing levels directly impact patient health and survival. *New England Journal of Medicine*, **346**(22), pp.1715-1722.

Royal College of Nursing (2000) *Setting safe nurse staffing levels. An exploration of the issues*. London: RCN.

Royal College of Nursing (2002) *Behind the headlines: A review of the UK Nursing Labour Market in 2001*. London: RCN.

Royal College of Nursing (2004) *Fragile Future?: A review of the UK Nursing Labour Market in 2003*. London: RCN.

Royal College of Nursing (2005) *Past trends, future imperfect ? A review of the UK Nursing Labour Market in 2004/2005*. London: RCN.

Royal College of Nursing (2006) *Setting appropriate ward nurse staffing levels in NHS acute trusts*. RCN policy unit. Policy Guidance. London: RCN.

Wilson-Barnett, J, (1978) *A review of patient nurse dependency studies*. London: DHSS. Nursing Division.

Braverman / Labour Process theory.

Attwell, P. (1990) What is skill ? *Work and Occupations*, **17**(4), pp.422-448.

Brannon, R.L. (1994) Professionalization and work intensification. Nursing in the cost containment era. *Work and Occupations*, **21**(2), pp.157-178.

Coombs, R. (1978) Labour and Monopoly capitalism. *New Left Review*, **107**(Jan-Feb), pp. 79-96.

Rinard, R G. (1996) Technology, deskilling and Nurses: The impact of the technologically changing environment. *Advances in Nursing Science*, **18**(4), pp.60-68.

Rose, D. (1995) *Official Social Classifications in the UK*. Social research update issue 9. <http://www.soc.surrey.ac.uk/sru/sru9.html>

Spencer, D.A. (2000) Braverman and the contribution of labour process analysis to the critique of capitalist production – 25 years on. *Work, employment and Society*, **14**(2), pp. 223-243.

Spenner, K.I. (1990) Skill: Meanings, methods and measures. *Work and Occupations*, **17**(4), pp.399-421.

Steinberg, R.I. (1990) Social construction of skill: Gender, power and comparable worth. *Work and occupations*, **17**(4), pp.449-482.

Vallas S P (1990) The concept of skill: A critical review. *Work and Occupations*, **17**(4), pp.379-398.

Care of the Health of Hospital Staff / Work Intensification.

Billeter-Koponen, S. and Freden, L. (2005) Long term stress, burnout and patient-nurse relations: Qualitative study about nurses experiences. *Scandinavian Journal of Caring Science*. **19**(1), pp.20-27.

Gardulf, A. Soderstrom, I-L. Orton, M-L, Erikson. L. E, Arnetz, B. and Nordstrom, G. (2005) Why do nurses at a university hospital want to quit their jobs ? *Journal of Nurse Management*. **13**(5), pp. 329-337.

HMSO (1968) *The care of the health of hospital staff*. Report of the Joint committee. London: HMSO.

Sheward, I. Hunt, J. Hagen, S. MacLeod, M. and Bal. J. (2005) The relationship between UK hospital Nurse Staffing and emotional exhaustion and job dissatisfaction. *Journal of Nursing Management*. **13**(1), pp.51-60.

Role Theory.

Banton, M. (1968) *Roles: An introduction to the study of social relations*. London: Tavistock.

Biddle. B.J. and Thomas, E.J. eds (1966) *Role Theory: Concepts and Research*. New York: John Wiley and Sons.

Hardy, M.E. and Conway, M.E (1988) *Role Theory. Perspectives for health professionals*. 2nd ed., California: Appleton and Lange.

Jackson, J. A. ed (1972) *Role: Sociological Studies 4*. Great Britain: Cambridge University Press.

Linton, R. (1936) *The study of man. An introduction*. New York: Appleton-Century-Crofts Inc.

Moorhead, S. (1997) *Nursing Roles: Evolving or recycled*. Series on Nursing Administration (SONA 9). London: Sage.

Professions and professionalization.

Carpenter, M. (1977) The new managerialism and professionalism in Nursing. *in* Stacey, M Reid, M. Heath, C. and Dingwall, R. *Health and the Division of Labour*. Croom Helm: London.

Carr-Saunders, A.M. and Wilson, P.A. (1964) *The professions*. London: Frank Cass and Co.

Derber, C. (1982) *Professionals as workers: Mental labour in advanced capitalism*. Boston. Massachusettes: G.K. Hall and Company.

Elliott, P. (1972) *The Sociology of the Professions*. London: Macmillan.

Etzioni, A. (1969) *The semi-professions and their organization*. Toronto. Canada: The Free Press. A division of the Macmillan Company.

Friedson, E. (1970) *Profession of medicine: A story of the sociology of applied knowledge*. New York: Dodd, Mead and Company.

Jackson, J, A, ed (1970) *Professions and Professionalization*. Sociological Studies 3. England: Cambridge University Press.

Keutzer, B. M. (1988) Fighting the currents towards professionalism. *Registered Nurse*, **October**, pp.21-22,24.

Moloney, J. (1986) *Professionalization of Nursing: Current issues and trends*. Philadelphia: JB Lippincott.

Porter, S. (1992) The poverty of professionalization: A critical analysis of strategies for the occupational advancement of nursing. *Journal of Advanced Nursing*, **17**(6), pp.720-6.

Schwirian, P. M. (1998) *Professionalization of Nursing. Current Issues and Trends*. 3rd ed., Philadelphia: JB Lippincott.

Vollmer, H.M. and Mills, D.L. eds (1966) *Professionalization*. Englewood Cliffs. New Jersey: Prentice Hall.

Appendices.

Appendix 1: Detailed descriptors of the three types of work in a hospital ward (Nuffield-Goddard 1953).

1) NURSING.

a) BASIC NURSING.

The essential characteristic of basic nursing is that it is UNIVERSAL. It is care required in the interest of the comfort and well being of the patient for the maintenance of health and prevention of infection, irrespective of the disease from which he is suffering. In a hospital ward, the main tasks of basic nursing are divided into 4 groups

- Daily hygiene
- Comfort in bed
- Feeding the patient
- Elimination of body waste

In addition to these tasks there are others, possibly related to social needs eg provision of places to see relatives, conversations with relatives, general conversation with patients, use of screens / curtains when privacy needed.

b) TECHNICAL NURSING.

All the nursing tasks concerned with treatment of disease from which the patient is suffering. The character of technical nursing is determined by the TYPE of WARD eg medical, surgical, paediatric and the treatment prescribed for a particular patient (whereas Basic Nursing is the same from ward to ward). The prime responsibility for this treatment rests with medical staff, but a large part of its carrying out is left to the nursing staff on the ward. The part which ward staff are called upon to play falls under 4 headings:

- Noting the treatment
- Preparing the patient for technical procedures
- Giving the patient GENERAL nursing care (keeping the patient under general observation eg post-operatively, if vomits)
- Assisting with or carrying out technical procedures on a patient

In addition to this is the preparation and maintenance of equipment used in the procedures, ordering supplies and checking drugs are part of technical nursing.

2) ADMINISTRATION AND ORGANIZATION.

- a) **Maintaining contact with other hospital departments** of which there are four:

- Matron and administrative nursing staff
- Technical departments - dealing with technical procedures ie Xray, theatre, path lab
- Maintenance departments and departments re general organisation of the hospital ie laundry, engineering, kitchen, porters
- Persons concerned with social aspects of ward life in reference to the patient ie hospital chaplain, almoner, librarian

NB: Persons from these departments visit wards and many may / may not require attention from ward staff at the time, also contact by telephone or sending staff to departments on an errand

b) **Internal organisation of a ward**, comprising three dimensions:

- Allocation of work to staff, a responsibility of the ward sister (but complex to analyse due to dual role of ward sister in training hospital for student nurse)
- Mechanics of organisation - mainly clerical ie requisitioning for patient tests and treatment, information to departments, ordering, charts up-to-date
- Use of staffs' personal time, personal needs and 'waiting time'

3) DOMESTIC DUTIES.

Fundamentally in a hospital ward, same as housewife / domestic worker engaged outside. The main cleaning duties are either heavy or light:

- **Heavy cleaning** - all the work connected with floors, cleaning paintwork / walls and scouring sinks, baths, toilets
- **Light cleaning** - general tidying, dusting, polishing and turning out cupboards. Also washing up.

Appendix 2: Technical nursing procedures observed (Nuffield Goddard 1953).

- (i) *Those medical procedures performed by the nurse which were usually included in daily (or frequent) rounds.*
- Examination of function: temperature, pulse, respiration, weight
 - Administration of drugs: oral, by injection (subcutaneous or intra-muscular)
 - Bandaging and dressing of wounds: drainage, irrigation, plugging and packing of wounds and orifices, removal of sutures and clips
- (ii) *Those medical procedures performed by the nurse when specifically required.*
- Enemata
 - Irrigation: rectal, bladder, gastric, nasal
 - Insertion of pessaries
 - Administration of drugs: rectal, by inunction, inhalation (including oxygen), suppository
 - Local applications: poultices, formentations
 - Baths and packs: icepacks, sponging, medicated baths
 - Removal of splints, weights, plasters
 - Artificial feeding: rectal, nasal, gastric
 - Stomach aspirations
 - Maintenance of infusions and transfusions
 - Last offices
- (iii) *Those procedures performed by either nurse or doctor (according to hospital policy).*
- Catheterization
 - Examination of function: Blood pressure
- (iv) *Those procedures performed by medical (or technical) staff for which a nurse may or may not have done the preparation or given other assistance in the ward.*
- Physical examination
 - Examination of organs: sigmoidoscopy, bronchoscopy
 - Examination of function: basal metabolic rate, electrocardiograph
 - X-ray
 - Immunization and sensitisation tests: Mantoux
 - Surgical operations
 - Application of plasters
 - Tapping (for relief and for specimens): abdominal, lumbar and sternal punctures
 - Chest aspirations (for relief and specimens)
 - Setting up infusions and transfusions
 - Administration of drugs: injections (intravenous)
 - Physiotherapy
- (v) *The collection and examination of specimens.*
- Swabs, smears, faeces, sputum: obtained by the nurse and tested in the laboratory
 - Blood: obtained by nurse, doctor, or technician and tested in the laboratories or doctors room
 - Urine: obtained by the nurse or doctor and tested in the ward or the laboratory
 - Gastric content: obtained by the nurse or doctor and tested in the laboratory
 - Pleural fluid, cerebrospinal fluid, bone marrow, tissue for biopsy: obtained by the doctor and tested in the laboratory

Appendix 3: The Briggs recommendations (HMSO 1972. pp. 212-217).

a) The statutory framework.

1. There should be a single central body responsible for professional standards, education and discipline in nursing and midwifery in Great Britain - The Central Nursing and Midwifery Council (618-623; 627; 632-639).
2. There should be three distinct Nursing and Midwifery Education Boards for England, Scotland and Wales, responsible to the Council (624-625; 627; 631-632; 634-639).
3. Midwifery interests should be represented by a statutory Standing Midwifery Committee of the Council. The committee would advise the Council and Boards on midwifery education and have direct control of midwifery education (626-629).
4. Below the three education boards there should be Area Committees for Nursing and Midwifery Education (640-648).
5. Responsibility for nursing and midwifery education should remain with DHSS, SHHD and WO (649-650).

b) Education.

6. Education should be regarded as a continuous process under unified control (253-255).
7. Colleges of Nursing and Midwifery should be established throughout the country financed through the Area Committees for Nursing and Midwifery education (346-348; 354-355).
8. The feasibility of setting up a number of Colleges of Health Studies should be explored (362-363).
9. Each College of Nursing and Midwifery should have a governing body with powers similar those of governing bodies in institutions for which local education authorities are responsible (349-351).
10. Each college should be under the direction of a Principal with the assistance of a Vice-principal (where necessary) and a lecturing and tutorial staff (352-353).
11. There should be close liaison for recruitment purposes between the Colleges and schools and the youth employment service (260).
12. There should be an increase in the number and range of pre-nursing courses, with nursing cadet schemes continuing as part of the range, under the title of preparation for Nursing Courses (261-265).
13. At the point of entry to the nursing and midwifery profession, applicants should be drawn from a wide range of intelligence from average to the highest. Suitability should not be determined by O levels alone (259).
14. The age of entry should be reduced in two stages to $17\frac{1}{2}$ in 1973 and 17 in 1975 (266-268).
15. There should be an annual national publication listing educational institutions and courses similar to the King Edward Hospital Fund for London Schools of Nursing Directory (269).
16. There should be one basic course of eighteen months for all entrants which would lead to the award of a statutory qualification, the Certificate in Nursing Practice (270-281).

17. Courses should be planned on a modular basis and should include experience in general and psychiatric nursing of the various groups in both hospital and the community. A defined amount of night duty should be part of the student's curriculum for its educational value alone. No un-Certified nursing student should be left in charge of a ward at night and there must be proper support at night and at week-ends in the clinical learning situation by teachers and senior staff (267; 270-284).
18. The eighteen-month course leading to Certification should be common to both prospective nurses and prospective midwives (303).
19. A further eighteen-month course, also on a modular basis, and open to only those holding the Certificate in Nursing Practice, should be provided. It should lead to a second statutory qualification, Registration. The new Register, unlike the present register, should not have separate parts (285-300).
20. For the more able students courses leading to Registration could include or be followed by courses leading to the award of a Higher certificate (non-statutory) in a particular branch of nursing or midwifery (285-287; 296-300).
21. There should be two ways of becoming a midwife:
 - a. Following Registration as a Nurse: a twelve-month course leading to Registration as a midwife and the award of Higher certificate;
 - b. Following the Certificate in Nursing Practice: an eighteen-month course leading to Registration as a midwife and the award of a Higher certificate (303-307).
22. Examinations for the statutory qualifications of Certification and Registration should be supervised by the three Education Boards who should use panels of external and internal assessors. The Boards should make a close study of assessment and examination techniques (308-310).
23. The Education Boards should consider the best forms of educational provision a) for graduates entering nursing, and b) in conjunction with universities, for students wishing to combine nursing with a degree (312-318).
24. Special training provisions should also be made for mature entrants: these should take account of their domestic commitments (319-322).
25. Nursing students recruited from overseas should be screened in their own countries wherever possible, and before beginning training they should be given effective orientation courses (323-326; 714).
26. Post registration courses, including clinical refresher courses, should be organised by the Education Boards as part of the on-going educational process (327-333).
27. There should be more 'back-to-nursing' and 'back-to-midwifery' courses for qualified returners and 'keep-in-touch' courses for non-practising qualified nurses and midwives who might subsequently return (335).
28. There should be a planned in-service training scheme for nursing aides. The scheme should be based on a nationally agreed syllabus (336-341; 715).
29. Students should continue to receive training allowances, which should be channelled through Area Education Committees, rather than student grants (360-361).
30. Nursing and midwifery education should include an introduction to the work of related professions such as the professions supplementary to medicine, and social work (364-367).
31. Educational and financial provisions must be made in order that the nursing and midwifery profession shall become more research based (370-378).

32. There should be improved continuity and coordination of education in classroom and service, with greater involvement of teachers in the service setting and the use of, for example, clinically expert ward sisters and their equivalents in Colleges (353-354; 356-358; 391).
33. It should be possible for people on the teaching staff of Colleges to hold honorary appointments in the service setting and vice versa (353; 356;391).
34. Teachers of nursing and midwifery must be adequately prepared. They should no longer be required to teach all subjects in the syllabus. The basic qualification for teachers should be a one-year course for the Diploma in Nursing and Midwifery education (383; 392-395).
35. There should be a major drive, started as quickly as possible, to produce more nursing and midwifery teachers (379; 396; 710).
36. In liaison with the Educational departments, the Health departments and the Central Council through its Education Boards should plan urgently a ten-year programme to increase the number of those holding the Diploma and to qualify more teaching staff generally (396-398).
37. There should be refresher courses for teaching staff, taking account of newly identified needs as they arise (399).

c) Manpower.

38. Efforts should be made to increase male recruitment (414-415; 435).
39. Increased training facilities should be made available to mature entrants (319-322; 433-434; 713).
40. Special attention should be devoted to the recruitment of more A level, undergraduate and graduate entrants (259; 312; 316; 318; 436).
41. Steps should be taken to encourage nurses and midwives whose careers are interrupted to return to the profession (335; 438-441).
42. Methods should be devised to ensure that health authorities can keep in touch with qualified nurses and midwives who cease to practise (441).
43. Manpower and personnel departments should be set up at regional and central, Area Health Authority/Board level. They should be concerned with all categories of staff in an integrated National Health Service (479; 499-511).
44. Within these departments help should be secured from specialists in disciplines such as labour economics, operational research and personnel management (502).
45. Senior Nursing Officer posts should be created at Area Health Authority/Board Level for nurses and midwives specially trained in manpower/personnel function (486).
46. As a matter of urgency, about one hundred people should be trained to fill these posts and a training programme should be developed to fill long-term needs (487-488).
47. Long-term and short-term objectives should be identified in order that the quality of patient care can be improved and resources can be used to the best effect (490-493).
48. A comprehensive information system should be developed by the Health Departments in cooperation with the central training bodies and regional and Area authorities, and should include data on rejected applicants (178; 500-501).

49. There should be closer liaison and more interaction between the Health Departments and those responsible for pay and conditions of service, training and personnel in the National Health Service (512).
50. Detailed manpower and personnel policies should have a long term dimension; in the interim, the Health Departments and the Regional Health Authorities should set minimum staffing ratios (514).
51. There should be more use of discriminatory budgetary procedures not only to assist the worse-off areas to catch up, but also to help them match resources to needs (515-518).

d) Conditions of work.

52. Where possible the long (twelve-hour) day should be discontinued (574).
53. Serious consideration should be given to arranging permanent night shifts in suitable areas in preference to rotation, and the organisation should ensure adequate up-dating, continuity of care and interchange of experience. Shift organisers generally should try to strike a balance between service requirements and staff wishes (570-575).
54. On-call systems should be reviewed and national agreements should be reached on a definition of the working week for community nurses and midwives (576-579).
55. A network of comprehensive counselling services should be set up urgently, incorporating academic advice, career guidance and personal counselling (580-592).
56. All nursing and midwifery staff should have access to an occupational health service (593).
57. The implementation of appraisal schemes should be carefully negotiated with full consultation at local level (595).
58. Personnel departments should, after consultation, devise a workable procedure for dealing with individual grievances (596-600).
59. The principle of representation of nurses and midwives by a nurse or midwife should be generally accepted, and some form of industrial relations training should be made available to nurses and midwives (600).
60. The powers at present vested in hospital authorities in certain circumstances to approve assisted travel schemes for staff within a fixed salary maximum should be extended to cover all grades. Car parking facilities for nursing and midwifery staff at hospitals should also be extended wherever possible (605-607).
61. Assistance of the type already given to nurses and midwives wishing to be seconded for study to complete a university course should be extended to post-graduate as well as undergraduate courses (608).
62. There should be a better general standard of accommodation, and there should be a designated officer generally responsible for staff accommodation (609).
63. Supervision of nurses' residences should be kept to a minimum, and there should be no need for a home warden for qualified staff. There should be adequate provision of changing and rest rooms (610; 613).
64. Authorities should give consideration to the provision of day nurseries and facilities (614).

e) Organisation of nursing and midwifery work and career structures.

65. Improved liaison between hospital and community services should be vigorously pursued (546; 551-552).
66. Ward organisation should, like the organisation of field work in the community, be, wherever possible, 'patient' rather than 'task' orientated (122-124; 133).
67. Cooperative teamwork and maximum delegation should be fostered at ward and field levels, and senior staff nurse posts should be created (127-134).
68. Differences in degrees of responsibility and expertise among ward sisters and their counterparts in community nursing and midwifery should be recognised by increased status and reward (541-542; 548).
69. There should be increased use of staff posts at various levels in both hospital and community nursing and midwifery in relation to (for example) personnel and research (545; 554).
70. There should be a continuing distinction of functions and qualifications between nurses engaged in family clinical (home nursing) and family health (health visiting) services (548).
71. Top nursing and midwifery administrative structures should build on present structures, and opportunities should be open to nurses and midwives from all fields to reach the top (550-554; 556).
72. There should be a strong nursing and midwifery team at Area level with executive functions (553).
73. The staff structure of the Colleges of Nursing and Midwifery should be separate from service structure and the Principal of each college should be responsible through the governing body to the Area Education Committee (555).
74. A new caring profession for the mentally handicapped should emerge gradually. In the meantime, in the training of nurses in the field of mental handicap, increased emphasis should be placed on social aspects of care (557-565).

f) Assimilation.

75. Assimilation arrangements should be negotiated in the light of the detailed plans drawn up by the new statutory bodies.

Appendix 4: **Strategy for Nursing: Key areas and targets for action (DOH 1989).**

| Key area | Target number | Target descriptor |
|----------|---------------|--|
| Practice | 1 | The full accountability of nursing, midwifery and health visiting practitioners, with responsibility for individual patients or clients should be recognised and applied in all health care settings. |
| | 2 | The development of Primary Nursing should be encouraged. |
| | 3 | New roles should be developed for practitioners to meet changing health care needs, improve care provision and realise the potential of clinical practice. |
| | 4 | Health education and promotion should be a recognised part of health care; all practitioners should develop skills in, and use every opportunity for, health promotion. |
| | 5 | The views and wishes of consumers should be taken into account in all decisions on the provision and delivery of health care. |
| | 6 | There should be agreed policies and procedures for setting standards of care and monitoring their outcome; practitioners should develop a knowledge of quality assessment. |
| | 7 | All clinical practice should be founded on up-to-date information and research findings ; practitioners should be encouraged to identify the needs and opportunities for research presented by their work. |
| | 8 | Academic facilities with departments of nursing should be encouraged to broaden their links with, and deepen their expertise in research based practice . |
| | 9 | The nursing professions should be represented on, and contribute fully to the work of the ethical committee . |
| | 10 | Practice-related and management information technology , of proven suitability, should be installed in all health care settings, all procedures - practice, organisational and managerial - should be examined and where desirable, computerized. |
| | 11 | All practitioners should be trained and experienced in the clinical use of information technology ; they should be enabled to maintain and build on any computer literacy acquired at school or during professional training. |
| | 12 | Health care facilities which could appropriately be led and managed by nurses , midwives or health visitors should be identified and developed. |
| | 13 | Clinical practice and policies should take account of national and local strategies for health . |
| | 14 | The contribution of specialist practitioners should be explored and developed in consultation with the medical profession where appropriate. |

| | | |
|-------------------|----|--|
| | 15 | The special contribution of the enrolled nurse to nursing practice should be recognised; the position of the individual nurse and of standards of care should be safeguarded. |
| Manpower | 16 | There should be strategic and operational plans for future manpower requirements which should be subject to regular review. |
| | 17 | Systematic methods should be used to agree numbers and deployment of staff in all health care settings. |
| | 18 | The grading structure for nurses , midwives and health visitors should be fine-tuned as appropriate to ensure that experience and responsibilities at all levels are recognized and acknowledged. |
| | 19 | The skills and make-up of each health care team, including the needs for specialist skills, should be reviewed at intervals in the light of changing needs. |
| | 20 | Sufficient ancillary, administrative and clerical staff should be provided in all health care settings to ensure the scarce professional skills are used to maximum effect. |
| | 21 | Recruitment plans should be developed and implemented, paying particular attention to the needs of mature entrants and those re-entering the service . |
| | 22 | Contact should be maintained with practitioners taking a career break, and flexible re-entry training programmes and conditions of service should be available to facilitate their return. |
| | 23 | The particular needs of practitioners with family commitments and those from ethnic minorities should be reflected in sympathetic and flexible personnel policies and practices. |
| | 24 | Employment of practitioners re-entering the NHS should take account of skills and experience gained in other health care settings or outside the professions. |
| Education. | 25 | All staff delivering health care should be appropriately prepared for their practice. |
| | 26 | There should be strategic and operational plans to meet the educational needs of the future professional workforce. |
| | 27 | The proposals for educational reform detailed in the UKCC document Project 2000 should be implemented. |
| | 28 | The education of nurses, midwives and health visitors should be regularly reviewed and adapted to ensure that it meets changing health care needs. |
| | 29 | The number and organization of schools of nursing and midwifery should be rationalized, and linked with establishments of further and higher education. |
| | 30 | All practitioners should have opportunities for continuing post-registration education appropriate to their work. |
| | 31 | Opportunities for enrolled nurse conversion to the first level should be increased to recognise and enhance their contribution to care. |

| | | |
|----------------------------------|----|---|
| | 32 | Practitioners should accept responsibility for ensuring their continued professional development and competence. |
| | 33 | Periodic and continuing education within the area of post-registration education and practice should be examined. |
| | 34 | The development of a comprehensive framework which allows the accumulation of credits towards graduate status should be pursued. |
| | 35 | Future teachers must be able to demonstrate at an advanced level a knowledge of the theory and practice of nursing and midwifery. They must be qualified or clinically credible in the area of practice they teach and hold a recognized teaching qualification |
| | 36 | Support workers accountable to nurses should receive training, within the framework of the NCVQ, to an appropriate level. |
| | 37 | Support workers with the appropriate qualifications, ability and desire to enter nursing education should be encouraged to do so. |
| | 38 | Management should ensure that policies, practices and procedures meet the objectives of the organisation. |
| | 39 | Management should set performance targets to agreed standards and ensure that staff complements are appropriate to meet them. |
| | 40 | Management should encourage and enable all practitioners to function at their highest level of ability. |
| | 41 | Nurses, midwives and health visitors should have access to an experienced senior practitioner for advice on professional issues; procedures should be in place to resolve ethical issues arising from individual clinical practice. |
| Leadership and management | 42 | Practitioners should be afforded personal appraisal of their performance and potential, advice on career options and appropriate training opportunities. |
| | 43 | All staff should, through their careers, be given the opportunity to develop their professional skills and capabilities; those opting for careers in management should be given the appropriate training and opportunities. |
| | 44 | Staff with special potential should be identified and given appropriate opportunities for development. |
| | | |

Appendix 5: **Summary of recommendations from The Virtue of Patients: Making the best use of ward nursing resources (Audit commission 1991).**

More large scale research is needed into nursing outcomes and how they are affected both by the numbers and mix of ward staff and by changes in nursing practice and organisation of care.

1. Delivering Better Patient Care.

- a. **QUALITY ASSESSMENT:** Patient opinion surveys should be improved to give more meaningful feedback on specific nursing issues of current relevance. There should be more systematic analysis of themes underlying comment and complaint.
- b. More use could be made by managers and nurses of indicators such as pressure sore incidence, hospital acquired infection rates, drug errors and patient falls to identify areas for fuller investigation. Quality of care should be assessed regularly and systematically using simple packages and results fed back promptly to wards.
- c. **QUALITY ASSURANCE:** Management should provide a structure and support for quality assurance initiatives, but nursing standards should be developed by ward staff and address the specific problems of each ward and the care of its patients.
- d. Management should promote nursing involvement in clinical audit. They should recognise and expand the role of nursing development units in developing and publicising good practice and should agree research and development plans with them.
- e. **MAKING CARE MORE PATIENT CENTRED:** Ward timetables should, as far as is possible, be organised around patients' needs and preferences. Management should monitor this and stimulate change through provision of professional development opportunities. They should facilitate dialogue between nurses and other professions to overcome any obstacles.
- f. Nurses and managers should show that good care planning matters by giving it adequate priority and time. Managers should ensure that care plans are audited periodically and that sisters allocate responsibility for assessing each individual patient, planning and monitoring his care to a named qualified nurse. Sisters should ensure that decisions about changes to a patient's nursing care are normally made only by that nurse.
- g. **IMPROVING CONTINUITY OF CARE:** If the spread of primary nursing is to improve care, deep-rooted attitudinal problems need to be addressed first. Those monitoring its implementation should concentrate on the principles of continuity: the duration of physical allocation of patients to specific nurses, responsibility for decisions and communication.
- h. Improved continuity will be dependent on better rostering and more stable ward staffing. Ward Sisters' 24 hour responsibility should be matched by control over night staffing. Transfer of patients between wards for non-clinical reasons should be avoided: if essential, more attention should be paid to identifying

suitable patients who are willing to move. Managers should ensure that nurses have a 'standard' for ensuring that continuity is maintained.

- i. Good team nursing may be a better way to promote continuity of care in the short term on wards where staff nurses are as yet unready to take on the additional responsibility of becoming a primary nurse. Nurses should be helped to change their practice through more, and better directed, professional development.
- j. Managers should support initiatives to improve continuity of care such as cutting out intermediaries when the nurses allocated to patients communicate with doctors and others.
- k. Each unit should have a **discharge policy** supported by training, monitoring and post-discharge feedback on specific patients. Discharge requirements should be assessed from admission. Managers should provide adequate resources and support for nurses to improve quality of patient information available on wards.

2. Staffing the wards

- a. **EMPLOYING THE 'RIGHT' NUMBERS AND MIX OF STAFF:** Managers should put in place structures to evaluate the effects of care delivery processes, on patient opinion and on staff of all significant changes to ward staffing levels, skill mix and also shift patterns.
- b. There should be periodic zero-based, *collaborative review of numbers and skill mix* reflecting *agreed* changes to nursing workload and provision of care. Ward activity should first be reviewed and managers should be involved in the review of action plans drawn up by ward sisters to improve efficiency and patient care.
- c. **Workload assessment** should be used to inform periodic review of staffing, but the data is more likely to be accurate and cost-effective if it is also of use to nurses on a day to day basis.
- d. Managers should facilitate **negotiated change to skill-mix** within agreed budgets where nurses consider this desirable to meet patient need. Reviews of support services should include evaluations of the likely effect on the level of non-nursing duties performed by nurses and their cost. Nationally £40 millions could be redeployed if best practice in reducing the amount of inappropriate clerical and housekeeping duties carried out by nurses were replicated.
- e. A co-ordinator should be nominated for **implementation of Project 2000** and to communicate decisions affecting the wards.
- f. **IMPROVING RECRUITMENT and RETENTION:** Managers should make better use of turnover and sickness data to identify potential retention problems in specific areas. Staff views should be surveyed periodically. Exit interviews and questionnaires should be used more systematically to find out why staff leave and to identify measures that might improve retention. Each unit should have a recruitment, retention and return strategy and should set annual targets for improved retention. Individual performance review (IPR) should be extended so that all staff receive adequate feedback on their performance.

- g. Effective use should be made of the **enrolled nurses**. Hospital policies which restrict their opportunities should be reviewed.
- h. Personnel departments should provide adequate **support for the recruitment of nurses**. Greater emphasis should be given to placing each nurse in the most suitable post. If possible, each applicant should be interviewed for several posts. Professional aspects of the induction process should be improved and mentors appointed for new post-holders.
- i. **DEVELOPING CLINICAL SKILLS:** Managers should provide adequate funding for post-registration education, time for study built into ward establishments and opportunities for cross-fertilization of ideas with nurses from other wards and hospitals. Nationally it would cost £60 millions to bring *average* levels of post-registration study up to those observed on wards that have adopted primary nursing, but disparities between wards and individual nurses must also be addressed.
- j. Individual performance review (**IPR**) should be used to identify professional and managerial development needs systematically and to provide data for a balanced post-registration education programme. Continuing training should also be provided for support workers.
- k. **MAKING BEST DAY-TO-DAY USE OF WARD STAFF:** Sisters should be given the education and freedom to negotiate new shift patterns appropriate to ward workload. They should receive help in overcoming barriers to change. In hospitals where there are long afternoon shift overlaps, managers should encourage sisters to review activities during these periods to see whether these could be accommodated more efficiently. Nationally £50 millions of nursing resources could be redeployed if overlaps were reduced to 1 hour.
- l. Training on good rostering which preserves continuity of care should be provided. There should be periodic management audit of the efficiency, effectiveness and equity of rosters.
- m. Workload assessment should be concentrated on helping nurses to control and pace their work better. Nurses should be moved from one ward to another only as a last resort, involving ward sisters in the decision.
- n. Managers should facilitate agreement between nurses and doctors on exceptional circumstances when insoluble shortages of nurses over a sustained period would make it advisable in the interests of patients to restrict workload. They should agree the procedures to be followed and methods to be used to reduce workload to levels reflecting nurses' availability - restricted admissions, case-mix, transfers, restricted nursing role.
- o. Flexible rostering agreements should be negotiated as an alternative to excessive employment of bank and agency nurses. Workload assessment and delegated budgets should be used to improve control over the use of temporary staff to 'make up the numbers'.
- p. Bank and other temporary nurses should normally be assigned only to wards with which they are familiar. Better induction should be provided for bank nurses.

3. Managing the nursing service.

- a. The role of nursing management should be to develop the service to meet patient needs. Middle managers of nursing should be clinically based. Responsibilities should be clarified.
- b. Day-to-day management of staff and budgets should be devolved to wards as far as possible. Sisters should be given the flexibility to exercise this extended management role positively and the preparation, training and support to do so effectively.
- c. The objectives of nurse management systems should be clarified and their proposed use 'modelled'. Computerisation of patient information used by nurses should be given priority. Training and support should be directed at improving nurses' awareness of how they can use systems to improve patient care.
- d. Many hospitals could **reduce nurse management costs** to 2 per cent of the nursing pay budget without sacrificing quality; nationally this could yield £35 millions for redistribution.
- e. Each hospital or unit should have a head of nursing (**Matron** or DNS) with a seat on the management board to provide professional leadership. She should have responsibility for nursing strategy, practice development and education, but not for day-to-day line management of nurses or nursing budgets.
- f. **A nursing strategy** flowing from analysis of patient needs and linked to hospital plans should be developed. Nursing developments should be integrated with those elsewhere so they reflect changes in hospital management and in medical practice.

Appendix 6: List of activities (Greenhalgh and Company 1994).

| Number | Activity |
|--------|---|
| 1 | Intubation during CPR |
| 2a | Infusion or bolus 1 st dose administration of drugs (excluding cytotoxic) - peripheral |
| 2b | Infusion or bolus 1 st dose administration of drugs (excluding cytotoxic) - central line |
| 3a | Infusion of bolus administration of drugs (excluding cytotoxic and 1 st dose) - peripheral |
| 3b | Infusion of bolus administration of drugs (excluding cytotoxic and 1 st dose) - central |
| 4 | Prescribing IV fluids |
| 5 | Insertion of a peripheral IV Cannulae |
| 6 | Insertion of a central line |
| 7a | Blood sampling - venous |
| 7b | Blood sampling - arterial |
| 8 | Defibrillation |
| 9 | Administering epidural analgesia |
| 10 | Recording ECGs |
| 11 | Insertion fine bore naso-gastric tube |
| 12 | Taking cervical smears |
| 13 | Changing tracheostomy tubes |
| 14 | Administering cytotoxic drugs |
| 15 | Confirming death at night when expected |
| 16 | Making the decision to adjust IV insulin dose according to sliding scale |
| 17 | Urethral catheterisation of Male |
| 18 | Referring patients for investigation |
| 19 | Removal of intercostal drain |
| 20 | Administering entonox |
| 21 | Administering contrast media |
| 22 | Diagnosing and prescribing treatment for acute minor illnesses eg. GU and respiratory infections |
| 23 | Prescribing medication for pain control |
| 24 | During the night prescribing night sedation |
| 25 | Having responsibility for seeing patients in pre admission screening clinics |
| 26 | Writing and signing prescription forms for drugs to take home |
| 27a | Writing and signing discharge and transfer letters - to GPs and other Drs |
| 27b | Writing and signing discharge and transfer letters - to District Nurses and other nursing staff |
| 28a | Take patient histories - with standard TPR / BP but excluding a full physical examination |
| 28b | Taking patient histories - including a full physical examination |
| 29 | TB testing |
| 30 | Skin tests |
| 31 | Immunisation and vaccination |
| 32 | Identify other technical activities in the speciality traditionally considered medical activities - but at times undertaken by nurses |

Appendix 7: **Report recommendations (Greenhalgh and Company 1994).**

The concept of Nurse and Junior Doctor sharing activities.

- 1) Should be some clarification of extended and expanded roles of nurses together with national guidance on terminology / roles NP / Nurse specialist.
- 2) If nurses are to undertake traditional medical activities...this must be introduced as 'sharing' the care for the benefit of the patient and the expansion of the role of the nurse, not as the wholesale 'transfer' of onerous tasks from junior doctors to nurses.
- 3) Such activities should become part of the role of all Registered ward nurses and not just the province of specialists or NPs or other staff groups.

Activities which could be shared.

- 4) Nurses should share in at least the following 6 activities ... both day and night ... but particularly at night ... supported by relevant procedures and protocols
 - ◆ Taking a patient history
 - ◆ Venous blood sampling
 - ◆ Peripheral cannulation
 - ◆ Referring a patient for certain investigations
 - ◆ Writing discharge letters to GP and other doctors
 - ◆ IVs peripherally (excluding 1st dose)
- 5) All 29 activities should be considered locally to ensure maximum nursing participation in them is achieved.

Quality of the environment and organisation.

- 6) Initiatives to promote collaborative practice should be pursued ... so that junior doctors and nurses plan care together.
- 7) Joint policies and procedures should be available for any of the 29 activities ... nurses and doctors should participate in drawing up such procedures.
- 8) Clinical protocols should be available for nurses to initiate the administration of medication and investigations for treatments, within ranges prescribed in advance by doctors for individual patients.
- 9) The integrated patient record should be developed as part of collaborative practice. Nurses should gather agreed core information ... relieving junior doctors of the need to spend time collecting this information.
- 10) Should be agreed core discharge letter which both nurses and junior doctors can use as appropriate.
- 11) Competency testing should be undertaken regularly for junior doctors and nurses
- 12) Ward induction for junior doctors should be undertaken to a standard which creates a ward team.
- 13) Supporting staff such as phlebotomists and ECG teams should provide a service to the wards.

Training implications.

- 14) Competency training for anyone asked to undertake the 29 activities

- 15) Competency training in at least the 6 activities which take up nearly 75% junior doctors time ... should be incorporated in core curriculum for pre reg nursing and undergraduate medical training.
- 16) Post basic training for nurses to obtain competency in the remaining 29 activities which are to be undertaken locally and to improve training for existing registered nurses in the 6 activities detailed above. Such competency training should be formally recognised so that it is transferrable between hospital units and trusts (eg using NVQ or occupational standards).
- 17) Training in the concepts and practicalities of collaborative care should be provided for both junior doctors and RNs as part of the basic core curriculum.

Further work.

- 18) Need for further testing work on the 29 activities, particularly the 6 key activities:
 - a. How much junior doctor time might be reduced by including travelling time ... etc
 - b. How acceptable are these changes to the NHS, to nurses, to doctors and to professional organisations
 - c. What are the training implications for doctors and Nurses depending on the various approaches available
 - d. What is the impact likely to be on existing nursing workload?
- 19) Further work on testing the views of patients about the quality of these activities when a nurse / dr undertakes them
- 20) Further work on at least the 6 activities to define measurable outcomes
- 21) Review of the skills required in cardiac arrest or crash teams in particular to explore and define the role which could be undertaken by ward nurses.
- 22) Further work to collect data on
 - a. Other junior doctor and nursing activities which staff other than nurses could carry out
 - b. The effect of consultant bed scatter on the ward team
 - c. Review this to evaluate the current initiatives involving support workers to junior doctors, in the light of the concept of patient focused care and with the aim of reducing the number of different staff attending patients.
- 23) Examine whether the four approaches to good practice identified in this report are flourishing there.

Appendix 8: Benefits of Nurses role expansion (SODOH 1996, p.38).

| Benefits to patients | Benefits to Nurses |
|--|---|
| <ul style="list-style-type: none"> • Increased quality of care and information to patients and relatives. • Increased patient choice. • Reduced waiting time. • Provision of more personalised and holistic care. • Reduction in the number of professionals with whom a patient has contact. • Improved chances of attending a 'one stop' service in out-patient departments. | <ul style="list-style-type: none"> • Increased job enrichment and job satisfaction. • Increased professional development. • Increased motivation and morale. • Improved career choices. • Increased availability of and access to nursing advice, information and expertise. • Increased professional credibility. • Increased professional pride. • Improved relationships. • Raised Nursing Profile. |
| Benefits to medical staff | Benefits to the organisation |
| <ul style="list-style-type: none"> • Contribution to the resolution of medical manpower problems. • Enable medical staff to prioritise activity eg more time available to treat very ill patients. | <ul style="list-style-type: none"> • Increased efficiency. • Facilitated shorter hospital stays. • Reduced waiting lists. • Improved cost effectiveness. • Contributed to the fulfilment of contracts and charter targets. • Increased organisational confidence in nurses and nursing. |

Appendix 9: **ENB (1992) 10 Key Characteristics and Associated Learning Outcomes.**

The 10 Key Characteristics.

1. **Ability to exercise professional accountability** and responsibility, reflected in the degree to which the practitioner uses professional skills, knowledge and expertise in changing environments, across professional boundaries, and in unfamiliar situations.
2. **Specialist skills, knowledge and expertise** in the practice area where working, including a deeper and broader understanding of client / patient health needs, within the context of changing health care provision.
3. Ability to **use research** to plan, implement and evaluate concepts and strategies leading to improvements in care.
4. **Team working**, including multi-professional team working in which the leadership role changes in response to changing client needs, team leadership and team building skills to organize the delivery of care.
5. Ability to develop and use **flexible and innovative approaches** to practice appropriate to the needs of the client/ patient or group in line with the goals of the health service and the employing authority.
6. Understanding and use of **health promotion and preventative policies** and strategies.
7. Ability to facilitate and **assess the professional and other development** of all for whom responsible, including where appropriate learners, and to act as a role model of professional practice.
8. Ability to take informed decisions about the **allocation of resources** for the benefit of individual clients and the client group with whom working.
9. Ability to evaluate **quality of care** delivered as an ongoing and cumulative process.
10. Ability to facilitate, manage and evaluate **change** in practice to improve quality of care.

The learning outcomes related to each of the 10 key characteristics.

The 10 key characteristics provide the basis for the Learning Outcomes required for the Higher Award. Practitioners, educationalists and managers need to use the Learning Outcomes when:

- **REVIEWING** practice, knowledge, skills and expertise.
- **IDENTIFYING** continuing education needs

- **DESIGNING** modular programmes, and
- **ASSESSING** continuing education activities.

Learning outcomes must meet the professional and academic standard and level specified by the Board. In each case, achievement of the Learning Outcomes will be demonstrated by change in practice within a specified group. The Learning Outcomes, for the 10 key characteristics are that: The practitioner must be able to demonstrate:

CHARACTERISTIC 1: The ability to exercise professional accountability and responsibility, reflected in the degree to which the practitioner uses professional skills, knowledge and expertise in changing environments, across professional boundaries, and in unfamiliar situations.

Explore concepts of self and take account of this knowledge and awareness in assessing the emotional impact of their work on clients, carers and team members.

Exercise professional accountability and responsibility, including the actions of others for whom they are responsible.

Understand and practice with an awareness of the legal, ethical, socio-economic and organizational aspects of care and health policy.

Recognize the parameters of their professional role, extend and expand these where appropriate to meet the changing health care needs of their clients, developing the role alongside and in conjunction with other health care workers in changing and differing situations.

Appreciate a wide range of management theories, select the appropriate model in a variety of situations and be efficient and effective in the management of the human and other resources for which they are responsible.

Use knowledge of the change process to become pro-active in their approach to change and be an effective change agent.

Provide an environment in which there is equal opportunity and a commitment to anti-racist, anti-discriminatory and anti-stereotyping practice.

Maintain competence and improve professional knowledge and expertise by identifying learning needs and evaluating professional development.

CHARACTERISTIC 2: Specialist skills, knowledge and expertise in the practice area where working, including a deeper and broader understanding of client / patient health needs, within the context of changing health care provision.

Provide care which applies specialist knowledge and skills to meet the needs of their specific client population, together with a broad understanding of health promotion and health care provision.

Apply in-depth knowledge of the physiological, pathological, psychological, sociological and cultural aspects which may influence the care of their client group.

Use knowledge of a range of theories and models of nursing, midwifery and health visiting practice to select appropriate strategies for the management and delivery of care for their specific client group.

Critically examine and promote change in delivery of care in the light of research findings specific to their client group.

Understand concepts of autonomy and advocacy, promote client autonomy and self-empowerment.

Create and maintain an environment in which carers and clients are enabled to make informed choices.

CHARACTERISTIC 3: Ability to **use research** to plan, implement and evaluate concepts and strategies leading to improvements in care.

Use knowledge of the principles and practice of research to create an environment where research awareness and an analytical approach to client care and health issues are valued by all staff

Identify sources of information and use information technology effectively in the collection and analysis of data.

Utilise research skills to critically appraise effectiveness of practice.

Understand ethical and legal issues for clients and practitioners when planning research-based care strategies.

Plan, implement, monitor and evaluate changes in care resulting from research.

Assist others in the use of analytical methods to evaluate care delivery.

CHARACTERISTIC 4: **Team working**, including multi-professional team working in which the leadership role changes in response to changing client needs, team leadership and team building skills to organize the delivery of care.

Use inter-personal skills effectively to relate to team members, clients and carers.

Understand the concept of role and potential role conflicts, actively encouraging a multi disciplinary approach to effective client care and recognise role boundaries within a collegiate team.

Display knowledge of the organisational structure, roles and relationships of other professional groups in promoting co-operative effective inter-professional multi-disciplinary, multi-agency working.

Integrate into the role a detailed knowledge of team structures and functions and individual responsibility within a team.

Encourage the contribution of client and carer in the team.

Understand theories of leadership and multi-disciplinary approaches to care in the light of changing legislation.

Promote team cohesion by facilitating group dynamics.

Work effectively as a member of a team, assuming and relinquishing leadership of the multi-disciplinary or multi-agency team where appropriate.

CHARACTERISTIC 5: Ability to develop and use **flexible and innovative approaches** to practice appropriate to the needs of the client/ patient or group in line with the goals of the health service and the employing authority.

Maintain and develop knowledge of advances in nursing, midwifery or health visiting theory and practice, and act as a catalyst for innovation.

Critically assess health care demands within an informed, flexible and innovative approach to meeting client needs.

Identify and advise others on the nursing, midwifery and health visiting component within organisational goals and effectively manage its implementation.

Promote nursing, midwifery or health visiting aims and values in the setting of organisational goals.

Justify risks in extending and expanding roles to meet the needs of the client group within the limits of the code of professional practice.

Develop confidence in the ability to move outside the boundaries of rigid structured behaviour and explore the limits of professional practice in the interest of clients and patients.

Show an awareness of the potential for conflict in a variety of settings, relate knowledge of conflict avoidance to effectively manage such situations.

CHARACTERISTIC 6: Understanding and use of **health promotion and preventative policies** and strategies.

Discuss and teach clients, carers and team members concepts of health promotion, health education, prevention and health protection.

Understand and apply the principles and practice of health promotion in the practitioners work setting.

Facilitate clients responsibility and choice for healthy living, and the ability to determine their own lifestyle.

Create, maintain and take responsibility for a health environment within their own work setting.

Encourage health promotion activities with clients, colleagues and carers.

Develop and implement strategies for health care following recognition of health trends and their impact on the cost and other resources.

CHARACTERISTIC 7: Ability to facilitate and **assess the professional and other development** of all for whom responsible, including where appropriate learners, and to act as a role model of professional practice.

Apply the principles of teaching, supervising, facilitating and assessing; select appropriate methods to meet specific situations.

Act as a role model in the practice area, encouraging staff in teaching, supervising, facilitating and assessing.

Create and sustain a supportive teaching and learning environment in their own practice setting.

Identify developmental needs of the staff for whom responsible, cultivate an awareness of the way in which these needs may be met; and report on a record of progress.

Encourage reflective and assured practice by helping members of their team make effective use of professional portfolios and other educational activities.

Maintain an awareness of the developments in nursing, midwifery or health visiting education and make the appropriate changes in their own practice setting.

Facilitate opportunities for counselling through understanding of the role which counselling plays in personal and professional development.

Facilitate the support which all staff require in order to develop and maintain confidence in the exercise of their practice and role.

Maintain awareness of educational programmes for allied health care groups and contribute to these where appropriate.

CHARACTERISTIC 8: Ability to take informed decisions about the **allocation of resources** for the benefit of individual clients and the client group with whom working.

Demonstrate the ability to utilize intuition and creativity in the process of decision making and facilitate the development of these skills in team members for whom they are responsible.

Utilise information technology for collection, storage and retrieval of data.

Collect, interpret and analyse essential data to inform decision-making, effectively manage the receipt and analysis of information and disseminate to appropriate personnel, of all levels in order to facilitate practice.

Use knowledge of health care economics to maximize human and other resources to their full potential in the achievement of quality health care for their clients.

Compile information in order to challenge and negotiate for resources or seek alternative strategies, to ensure an agreed standard of care for clients.

Use current knowledge of resource management information to make informed decisions in the provision of care to the client / client group for whom they are responsible.

CHARACTERISTIC 9: Ability to evaluate **quality of care** delivered as an ongoing and cumulative process.

Explore concepts of quality assurance and client participation in evolving standards.

Use knowledge of national and international practice to review tools for the measurement of quality of care and evaluating current practice.

Include team members, clients and carers in setting standards for their client group.

Produce a client oriented quality programme, monitoring and evaluating its implementation.

Develop a quality environment to enable the delivery of a standard of care which will meet the professional values of nursing, midwifery and health visiting.

Use the results of evaluation to sustain or improve quality of care programmes.

Value the contribution of the caring team, involving clients, carers and team members in setting relevant standards of care.

CHARACTERISTIC 10: Ability to facilitate, manage and evaluate **change** in practice to improve quality of care.

Understand the processes of determining the need for managing and evaluating change.

Act as an effective change agent and provide up-to-date approaches to health care for their particular client group.

Take account of local, organizational and national policies and trends which may influence the management of change.

Appendix 10: Vision for the future: Twelve Targets (DOH 1993).

Preamble:

This is a considered view of the future for Nurses, midwives and health visitors and the contribution they can make to the NHS changes set out by the government in four policy initiatives: Caring for people, Health of the Nation, The Children Act and The Patient's Charter. The details are laid out in Five Key Areas and Twelve Targets:

A Vision for the Future.

The future imperative for nursing, midwifery and health visiting must be to work in partnership with other professionals, users of services and carers. This participation will improve the general health and life expectancy of the whole population ... the end result of these new initiatives will be an understanding of each individual, and a desire to participate with them in their health care in a way that preserves their dignity.

5 ways to achieve this:

1. Quality, Outcomes and Audit: To provide care on an individual basis, with the outcomes charted and the delivery submitted to audit.
2. Accountability for practice: To develop an awareness of the duties and obligations connected with individual professional accountability.
3. Clinical and professional leadership, clinical research and supervision: To develop clinical and professional leadership in a corporate management agenda.
4. Purchasing and commissioning: To consider how clinical and professional expertise might feed into the commissioning and purchasing cycle.
5. Education and professional development: To ensure that the educational and personal development needs of practitioners are met in order for them to deliver high quality care.

The 12 targets.

- Target 1:** Professional and clinical leaders, whether in the statutory, private or voluntary sector should ensure that there are systems in place to encourage and facilitate development of individualised patient care, and where this is not the case to have at least one pilot project in place and ready for evaluation by the end of the first year. In the first year each patient / client should have been assigned to a named nurse ... local units will be expected to have developed the means of monitoring the named nurse ... initiative.
- Target 2:** At the end of the first year a consumer satisfaction survey on the quality of the partnership and users involvement in care should have been completed and the findings conveyed to nurses ... concerned.
- Target 3:** By the end of the first year all provider units should have identified three outcome indicators responsive to nursing ... practice, develop relevant protocols and have in place, as part of the management

organisation, a framework of clinical audit to establish baseline data against which local targets can be set for the future.

- Target 4:** At the end of the first year purchasers and providers should be able to demonstrate that they are including value for money recommendations in their contracts for service.
- Target 5:** At the end of the first year clinical and professional leaders should have taken steps to discuss with each nurse ... how they might develop their practice.
- Target 6:** At the end of the year each nurse ... should be able to clearly identify the caseload or group of patients ... for whom he/she is the named professional and for whom he/she bears a responsibility for care.
- Target 7:** At the end of the first year employing authorities will need to demonstrate what action they have taken to identify and support those with the potential to develop leadership and management skills.
- Target 8:** At the end of the first year professional leaders should be able to demonstrate the existence of local networks to disseminate good practice based on research.
- Target 9:** By the end of the year providers should be able to demonstrate at least three areas where clinical practice has changed as a result of research findings.
- Target 10:** Discussions should be held at local and national level on the range and appropriateness of models of clinical supervision and a report made available to the professions by the end of the year.
- Target 11:** By the end of the year good practice from leading edge purchasing authorities demonstrating the input of nursing ... advice should be drawn together and shared with other purchasing authorities.
- Target 12:** At the end of the year each provider unit should be able to identify particular pre-and post-registration programmes planned to help nurses ... acquire the necessary skills associated with Health of the Nation, caring for people and the Patient's Charter/Named Nurse initiative.

Appendix 11: 'Making a Difference' summary (DOH 1999) .

This is an 82 page document detailing the 'New Vision' for the future of Nurses, Midwives and Health Visitors within the NHS - in this increasingly sophisticated world.

It has been published in the Labour Party office, and should be viewed together with the 10 year programme of NHS Reforms detailed within the two major Labour Party reports:- The New NHS - Modern and Dependable and A First Class Service.

Statistics related to NHS Nurses, Midwives and Health Visitors (N, M & HV).

NHS employs over 332,000 N, M & HV - they constitute the largest group of health professionals (biggest staff group) in the NHS.

| | | |
|--------------------------|---------|-----------------------------------|
| In England, NHS employs: | 332,000 | WTE, N, M & HV |
| | 247,240 | qualified |
| | 18,170 | MW |
| | 10,070 | HV |
| | 10,360 | (WTE) Nurses in General Practice. |

The backdrop or context in which N, M & HV practice within the NHS is acknowledged as changing in the following areas:

- Health and social needs
- Technology
- People's expectations
- The NHS itself under the 10 year programme of reform
- Roles are changing.

Additionally, it is acknowledged there are Constraints and Limitations for N, M & HV, which are often due to structures which limit development and innovation. Some of these issues include:

- **Recruitment and Retention** of staff.
- **Education and Training** - newly qualified are poorly skilled. Lifelong learning is a must for the majority.
- **Pay and Careers** - current clinical grading no longer appropriate. Absence of career paths.
- **Working Lives** - many N, M & HV are women, and are disadvantaged with current working situation.
- **Professional Self Regulation** - acknowledged that a more open, responsive and accountable system needed to secure public protection and confidence.
- **Better reflecting the communities served** - aim here is to have professionals able to provide culturally sensitive and responsive services, care and support.

Having identified the changing context of practice and the constraints and limitations, the report details an '**Agenda for Action**' to address these - they are now listed:

- Recruit more nurses
- Strengthen education and training
- Develop new, more flexible career structure
- Improve working lives
- Enhance the quality of care
- Strengthen leadership
- Modernise professional self regulation
- Support new roles and new ways of working.

Recruiting More Nurses.

Proposed expansion over next 3 years of 15,000 more nurses taken on in NHS.

Increase nurse training places over next 3 years and reduce the drop-out rates.

Bring quality staff back to the NHS.

Improve workforce planning through getting to grips with future staffing requirements.

Strengthening Education and Training.

Strengthen pre-registration education (Partnerships between Trusts and University)

UKCC Commission for Education (Peach Report, September 99, Fitness for Practice).

More flexible career paths into and within Nurse Education (a stepping on and stepping off approach).

Better practical skills - want higher quality and longer placements in a genuinely supportive learning environment. Important Nurses taught by those with practical and recent experience in Nursing to achieve the need to:

- set clear targets for boosting teacher support for students on placements and increase the pace of joint appointments with universities.
- create more opportunities to combine teaching and patient care.
- enhance the status of those that provide practice based teaching.
- need to ensure training is responsive to NHS needs through DOH establishing a PARTNERS Council to bring together stakeholders, university, patient reps and NHS to ensure the joining up of professional development, education, research and a framework for post-registration. Proposed that need same standards and skills wherever trained so need to agree OUTCOMES for the end of each of the 3 years.
- clear commitment to Continuous Professional Development (CPD) and lifelong learning essential to achieve continuous quality improvement (must be linked to local needs and individuals needs).

- need introduction of Personal Development Plans (PDPs) identified in 'Working Together' - linked to performance appraisal and organisational objectives.
- Work-based learning linked to multi-professional teams to be encouraged.

Developing a Modern Career Framework

A new career structure is proposed to replace clinical grades to facilitate a better career progression and fairer rewards, and to allow better opportunities to combine or move laterally between jobs in practice, education and research.

A broad view of the new career structure is:-

| | | |
|------|--------------------------------|------------------------------|
| I. | HCA's | (NVQ) |
| II. | Registered Practitioner | (Dip/1 st Degree) |
| III. | Senior Registered Practitioner | (1 st /Masters) |
| IV. | Consultant Practitioner | (Masters/PhD/Higher) |

Improving Working Lives

Need to modernise working conditions - balance between work and home.

NB - many other supporting documents on this aspect of the strategy.

Enhancing the Quality of Care

This chapter basically reiterates and cross references with the governments white paper 'A First Class Service'.

Strengthening Leadership

Programmes of modernisation present a challenging leadership agenda, requiring VISIONARY leadership - strung at each level of N, M & HV.

The purpose of visionary leadership is to:

- Drive forward interagency and multidisciplinary team working.
- Implement quality and practice through clinical governance.
- Lead public health initiatives.
- Plan and commission services through PCG's and Trusts.
- Provide effective management of clinical services and corporate functions

Modernising Professional Self Regulation

It is made clear that individuals are responsible for the quality of their OWN clinical practice - but it is noted that Professional Autonomy is a privilege and a significant responsibility, which must be matched by a commitment to Public Accountability.

Professional Self Regulation is a Cornerstone of Public Protection.

Quote P57

We expect every N, M & HV to understand fully the obligations associated with professional registration and accountability. They should practice in accordance with the UKCC N, M & HV Code of Professional Conduct and related guidance. We expect them to maintain and improve their professional knowledge and competence - at the very least to the minimum required during each registration cycle - and to acknowledge any limitations in knowledge or competence, undertaking new or expanded responsibilities in accordance with current guidance about the Scope of Professional Practice.

Commission reviewed N, M & HV Act and identified weaknesses. A new plan for a new statutory regulatory framework is in preparation.

Working in New Ways

Extend role of N, M & HV to make better use of their knowledge and skills, including making it easier for them to prescribe.

Needs careful management of new roles/role development. And this needs to be a managed process.

There is to be increased teamwork, collaboration and partnerships.

NB - Also included in the document is a chapter on making it happen and timescales for introducing the innovations are outlined as a list of early milestones.

Appendix 12: Peach Report recommendations (UKCC 1999).

Increasing flexibility.

1. Careers services should offer a breadth of advice which encourages access for all, both those with no formal qualifications as well as graduates
2. Recruitment and selection should be a joint responsibility between service providers and HEIs.
3. The good practice of service providers, HEIs and EEIs co-operating to provide entry to pre-registration nursing and midwifery programmes through a year 0 (access) programme should be extended.
4. The use of AP(E)L should be introduced to allow for more flexible entry to pre-registration nursing programmes.
5. The year 1 CFP should;
 - a. Enable students to achieve a common level of competence at the point of entry to the branch programme
 - b. Be reduced to one year
 - c. Be taught in the context of all four branches
 - d. Enable integration with the branch programme
 - e. Ensure that practical skills and placements are introduced at an early stage in the programme
6. Students who choose to leave the pre-registration nursing or midwifery programmes having successfully completed at least year 1/CFP should be able to benefit from their academic and practice credit by having it mapped against other credit frameworks regulated by the statutory regulatory authorities in each of the four countries.
7. Recognising the constraints, more flexibility should be introduced for pre-registration nursing programmes concerning the point at which the branch selection is made, with options being available at both the point of recruitment and during year 1 / CFP. Where possible, students should be asked to nominate a first and second choice of branch programme.
8. The commission urges an expansion of graduate preparation for nursing and midwifery because of:
 - a. The nature of clinical decision-making required
 - b. The current demands of service providers, particularly for workforce flexibility and role diversity
 - c. The close approximation of the current diploma preparation to graduate level
 - d. Government targets for participation in higher education
 - e. The increasing demand for graduate nursing places but limited supply of places
 - f. The increasingly competitive labour market

- g. Career expectations of young people
- 9. A common definition of attrition and a required minimum data set for pre-registration programmes should be agreed and put in place for use across all four countries of the UK

Achieving fitness for practice.

- 10. The standards required for registration as a nurse on parts 12, 13, 14 & 15 of the UKCC register should:
 - a. Be constructed in terms of outcomes for theory and practice
 - b. Make the 50% practice component of the course hours transparent
 - c. Specify that consistent clinical supervision in a supportive learning environment during all practice placements is necessary
- 11. The subject benchmarking to be undertaken by QAA should be jointly developed with the UKCC and the National Boards and should address outcomes which are:
 - a. Core and specific to nursing
 - b. Core and specific to midwifery
 - c. Transferable
 - d. Consistent with the QAA threshold for degrees and diplomas
- 12. Consideration should be given as to whether pre-registration midwifery education should move to an outcomes-based competency approach
- 13. Students, assessors and mentors should know what is expected of them through specified practice outcomes which:
 - a. Form part of a formal learning contract
 - b. Give direction to practice placements
 - c. Are jointly negotiated between the service providers and HEIs
- 14. The use of a portfolio of practice experience should be extended to demonstrate a student's fitness for practice and provide evidence of rational decision making and clinical judgement
- 15. The portfolio should be assessed through rigorous practice assessment tools which identify the skills which students have acquired and highlight any deficits which need to be addressed.
- 16. The sequencing and balance between university and practice-based study should be planned to promote an integration of knowledge, skills and attitudes.
- 17. The current programme model of four branches of nursing should be reviewed in the light of changing health care needs. The review should consider a range of options including a redefinition of branch structures and generalist nurse preparation.
- 18. Practice placements should be designed to achieve agreed outcomes which benefit student learning and provide experience of the full 24 hour per day and seven day per week nature of health care.

19. To make best use of practice placements, interpersonal and practice skills should be fostered by the use of experiential and problem-based learning, increased use of skills laboratories and access to information technology, particularly in clinical practice.
20. To enable nursing and midwifery students to consolidate their education and their competence in practice, there should be a period of supervised clinical practice of at least three months towards the end of the pre-registration programme. This practice period is intended to be a transitional period with clearly specified outcomes and should be managed by specifically prepared nurses and midwives.
21. All newly qualified nurses and midwives should receive a properly supported period of induction and preceptorship when they begin their employment.
22. Programme changes resulting from the Commission's recommendations should be systematically evaluated in respect of achieving fitness for practice.

Working in partnership.

23. Service providers and HEIs should continue to develop effective, genuine partnerships to support:
 - a. Their respective commitment to students
 - b. Curriculum development, implementation and evaluation
 - c. Joint awareness and development of service and education issues
 - d. Delivery of learning in practice
 - e. Defining responsibilities for underpinning learning in practice
 - f. Monitoring the quality of practice placements
24. An accountable individual should be appointed by purchasers of education to liaise with service providers and HEIs to support
 - a. The provision of sufficient suitable practice placements
 - b. Staff and students during placement
 - c. The development of standards and specified outcomes for placements
 - d. The delivery and effective monitoring of the contract to ensure that the contractual requirements are met
25. Recognising that no individual can provide the full range of expertise required by students, service providers and HEIs should work together to develop diverse teams of practice and academic staff who will offer students expertise in practice, management, assessment and mentoring and research.
26. Service providers and HEIs should support dedicated time in education for practice staff and dedicated time in practice for lecturers to ensure that practice staff are competent and confident in teaching and mentoring and lecturers are confident and competent in the practice environment.
27. The good practice of formalised arrangements for access to practice for lecturers and to education for practice staff should be adopted by service providers and HEIs.

28. Service providers and HEIs should formalize the preparation, support and feedback to mentors of pre-registration students. This should be continued by service providers, in line with best practice, for preceptors of newly qualified nurses and midwives.
29. Funding to support learning in practice should be reviewed to take account of the costs of mentoring and assessment by practice staff and the cost of lecturers having regular contact with practice.
30. To improve workforce planning for nursing, NHS requirements should increasingly be informed by comprehensive information from the private and independent sector.
31. Taking into account changes in health and social care delivery, the government departments of health, social care and social services, education and employment, in each of the four countries, should work together to ensure that the preparation of health care assistants and social care assistants is based on common standards.
32. The health care professions should be actively encouraged to learn with and from each other by:
 - a. Purchasers of education including inter-professional teaching and learning - as appropriate - as a criterion for evaluating the quality of education
 - b. Explicit encouragement for inter-professional learning in the planning of all pre-registration curricula
 - c. The development of shared learning resources and technology in practice placements
 - d. The UKCC leading joint initiatives with relevant regulatory bodies
33. We recommend that consideration should be given to the most appropriate method of funding students of nursing and midwifery in the future. The forthcoming government review of nursing, midwifery and professions allied to medicines (PAM's) student funding in England should consider the professed willingness of the private and independent sector to participate in funding students.

Appendix 13: **Four statutory practical assessments for entry to the professional register (GNC 1969).**

General advice for examiners:

1. Ensure that the working conditions are as near normal as possible.
2. Candidates **MUST** only be examined on the performance **DURING THE EXMINATION**. Decisions are **NOT** to be influenced by previous knowledge of the person's work or progress.
3. You are required to indicate, with a tick in the appropriate column, your opinion of the candidate's performance of each item as follows:
 - a. Part A and Part B – safe or unsafe
 - b. Part C and part D – satisfactory or unsatisfactory

Any ticks in either the unsafe or unsatisfactory columns may necessitate the intervention by the examiner to avoid discomfort or risk to the patient. If any item is not applicable, leave the space blank.

4. All candidates are to be notified of the result at the end of the examination and be given the opportunity to see the mark sheet and discuss the performance. The result is to be entered in the Practical Record book of the candidate.
5. Candidates who are referred should be given the opportunity to practice the procedure in order to re-enter after a period of 7-14 days has elapsed.
6. The mark sheet must be returned to the teaching department as soon as possible after the conclusion of the examination.
7. No examiner is to take any **THIRD ATTEMPT** until the Director of Nurse Education, or his deputy, has been informed and given a ruling on the case.

Student Nurse Ward Examination

Part A: Aseptic Technique.

NAME:

Group

Senior Tutor:

Date:

Ward:

Index No:

Attempt 1 2 3

| | Safe | Unsafe | Comments |
|---|------|--------|----------|
| Preparation of self. | | | |
| Preparation of equipment. | | | |
| Preparation of patient, including positioning and establishment of rapport. | | | |
| Sequence of aseptic procedure. | | | |
| Maintenance of asepsis. | | | |
| Manual dexterity. | | | |
| After care of patient and clearing away of equipment. | | | |
| Clarity and accuracy of report to the nurse in charge. | | | |
| Questions: Knowledge and understanding of the following: | | | |
| A) the patient's illness and the need for this specific aseptic procedure. | | | |
| B) the prevention of cross infection in the surgical ward. | | | |
| c) the management of drainage tubes, packs and sutures. | | | |

Nurse's signature..... Examiner's signature

PLEASE RETURN THE COMPLETED FORM TO THE SENIOR TUTOR IN THE SCHOOL OF NURSING.

Part B: Administration of medicines.

NAME:

Group

Senior Tutor:

Date:

Ward:

Index No:

Attempt 1 2 3

| Organisation: | Safe | Unsafe | Comments |
|---|-------------|---------------|-----------------|
| Preparation of equipment and drugs. | | | |
| Reading prescription charts correctly. | | | |
| Observation of patient before giving drugs. | | | |
| Measuring, checking drugs. | | | |
| Administration and recording. | | | |
| Clearing away equipment after use. | | | |
| Knowledge of drugs: | | | |
| Action of drug. | | | |
| Signs of overdose, and action to take if present. | | | |
| Possible side effects. | | | |
| Dosage. | | | |
| Controlled drugs: ordering, storage and administration. | | | |
| Communication: | | | |
| Establishing rapport | | | |
| Precision with colleagues | | | |
| Accuracy of reporting to sister | | | |

PASS

FAIL

REFER

Nurse's signature Examiner's signature

PLEASE RETURN THE COMPLETED FORM TO THE SENIOR TUTOR IN THE SCHOOL OF NURSING.

Part C: The planning and carrying out of the nursing care required by a patient during a span of duty, a suitable part of this to be observed by the examiner (Total Patient Care).

NAME: _____ Group _____ Senior Tutor: _____
 Date: _____ Ward: _____ Index No: _____
 Attempt 1 2 3 Time allowed: 4-6 hours.

| | Satisfactory | Unsatisfactory | Comments |
|--|--------------|----------------|----------|
| Organisation skills: | | | |
| Assessment of care required. | | | |
| Planning of the order of care required. | | | |
| Communication skills: | | | |
| Establishing rapport with the patient. | | | |
| Maintaining the dignity and individuality of the patient | | | |
| Ability to communicate by verbal and written means. | | | |
| Communication with other hospital staff and visitors, if applicable. | | | |
| Technical / clinical / nursing skills: Proficiency in nursing care: | | | |
| Skill in carrying out the nursing procedure. | | | |
| Skill in carrying out the clinical procedure. | | | |
| Manual dexterity in handling of the patient. | | | |
| Skill and dexterity in the use of equipment. | | | |
| Knowledge: | | | |
| Knowledge of the illness. | | | |
| Methods of treatment | | | |
| Ability to apply this knowledge to this particular patient. | | | |

PASS FAIL REFER

Nurse's signature..... Examiner's signature.....

PLEASE RETURN THE COMPLETED FORM TO THE SENIOR TUTOR IN THE SCHOOL OF NURSING.

Part D: Communication & Organisation for a ward/group of 10-12 patients.

NAME: _____ Group _____ Senior Tutor: _____
 Date: _____ Ward: _____ Index No: _____
 Attempt 1 2 3 Time allowed: 4-6 hours.

| | Satisfactory | Unsatisfactory | Comments |
|---|--------------|----------------|----------|
| A) The organisation of the duties of the ward staff for a span of duty: | | | |
| 1) Assessment of needs to be carried out. | | | |
| 2) Planning of the order of work. | | | |
| 3) Ability to make full use of resources. | | | |
| B) The giving of a verbal report to the examiner similar to one which would be given to a member of the medical staff. | | | |
| 4) Knowledge of patients' illnesses and method of treatment. | | | |
| 5) Knowledge of patients' backgrounds and relevance of illness. | | | |
| 6) Establishing rapport with the patients. | | | |
| 7) Ability to select the salient points. | | | |
| 8) Ability to report the progress of the patient's condition. | | | |
| 9) Ability to report adverse effects of treatment. | | | |
| 10) Accuracy of the report. | | | |
| C) The recording of progress reports and the giving of a report when handing over at the end of a span of duty. | | | |
| 11) Selection of the appropriate facilities. | | | |
| 12) Choice of words and legibility of writing. | | | |
| 13) Ability to convey by words the salient points. | | | |
| 14) Accuracy of the report. | | | |
| 15) Clarity of expression. | | | |
| 16) Ease of communication. | | | |
| D) Professional behaviour: | | | |
| 17) Ability to deal with emergencies. | | | |
| 18) Ability to teach junior staff. | | | |
| 19) Ability to establish a good working relationship. | | | |
| 20) Relationship with senior staff. | | | |
| 21) Relationship with other hospital staff and visitors. | | | |
| 22) Health and safety at work aspects. | | | |

PASS FAIL REFER

Nurse's signature..... Examiners signature.....

PLEASE RETURN THE COMPLETED FORM TO THE SENIOR TUTOR IN THE SCHOOL OF NURSING.

Appendix 14: BJN (1935) Revised Nomenclature.

Nomenclature for Nurses (BJN 1935).

- Matron
- Assistant Matron
- Home Sister
- Sister Tutor
- Night superintendent or Sister
- Ward Sister
- Staff Nurse
- Senior Assistant Nurse
- Assistant Nurse
- Probationer
- Male Nurse
- Male Attendant

Suggested application of revised nomenclature (BJN 1935).

In General Hospitals and Infirmaries:

- a) terms matron, assistant matron, home sister, sister tutor, night superintendent or sister, ward sister, staff nurse and male nurse should not be used unless the Nurses are fully trained and entered in the General part of the state register.
- b) terms Senior assistant nurse, assistant nurse, male attendant and probationer be used in the case of nurses not possessing the foregoing qualifications.

In Special hospitals and Institutions:

- a) term matron, assistant matron and sister tutor should be applied only to those nurses who are fully trained and entered on the general part of the state register; while the titles home sister, night superintendent or sister, ward sister, staff nurse and male nurse should signify nurses who have been fully trained, although they might be entered only under the appropriate section of the SUPPLEMENTARY state register.
- b) As in the case of general hospitals and infirmaries the descriptors senior assistant nurse, assistant nurse, male attendant and probationer should be used for untrained nurses.

Appendix 15: Organisational literature retrieved during fieldwork.

- A. Nil
- B. Handwritten fieldnotes
- C. Handwritten fieldnotes
Nursing establishment ending December
- D. Sisters' meeting minutes
Patient participation questionnaire
Handwritten fieldnotes
Overseas recruited nurses: names/clinical areas
- E. Protocol out of hours call out of Junior Drs
Verification of expected death
- G. My audit type document
- H. Ward patients green cards.
- HH. Nil
- I. Welcome to the upper GI team
Protocol - upper GI nursing service
Clinical skills facilitator - retention strategy - job description
Referral proforma
PPT - upper GI nursing service
Cancer pathways
Article - workloads and outcomes
- J. Staff nurse programme
Planned lecture programme
Staff nurse assessment documents
- K. Nil
- L. Hospital to home - supporting documents
TURP care pathway
- M. A25 student response documents to pre- and post-op objectives
- N. Sisters' meeting agenda
New consent documents
- Q. Critical Care meeting minutes (from S of H)
In house training programme
Critical care pre-reg module guide
Clinical critical care learning package
- R. Primary Nursing booklet
Patient profiles
- s. Letters from management
 - memo staffing levels Degas
 - letter staffing levels Rodin
 - speciality manager letter - staffing levels Klimt / Degas
 - nursing teams
 - VSU/study leave
 - Shift pattern changes
 - Night senior nurse cover
 - Critical Care bed management
 - ITU survey - outreach services
- T. Draft protocol (vascular)
Letters

- Audit of stockings
- U. DVT and travel
 - 4 line bandaging
 - Day surgery centre documents
- V. Sisters' meeting - agenda
 - May minutes
 - 'Easy care' single assessment
 - Notes from meeting
 - Draft whistle-blowing policy
 - Minutes July meeting
- X. Clinical governance - previous meeting minutes
 - Survey patient satisfaction
 - M & M old document
- Z. Sisters' meeting - essence of care timetable
 - Original fieldnotes
 - Agenda
 - Minutes previous meeting
 - Financial support for return to nursing
 - Lost dentures
 - BNA letter
- EE. List of patients
 - NNP job description
 - NNP duty rota
- GG. Bowel cancer leaflet
- II. 10 transcripts of training (new juniors)
 - Trust Talk
 - Communication sheets on in-patient wards
- JJ. Urology ward minutes
 - Trust healthcare plan
 - Letter skill mix review
- KK. Urology ANP timetable
- LL. DOH informed consent booklet
 - Trust consent document
 - SSU research abstract
 - SSU consultant preferences booklet
 - Minutes Sr's meeting Aug 7th
 - August - Clinical Governance update
 - Clinical governance incident codings
 - In-house HDU training programme
 - July - manager meeting minutes
 - Blood forms
 - Letter re ward assistants
 - Lap chore book
 - Lap chore care path
- QQ. Sisters meeting agenda/previous meeting minutes
 - NVQ training D32/33
 - Associate Nurse grade development programme
 - 2 wards duty rota
 - Establishment - end June
- SS. Cannulation self assessment documents

- Protocol IV drug administration
- NHS patient information - appendectomy
- Trust Annual Report
- Surgical directorate - information for junior dr's
- BBB. Divisional Sisters' meeting - agenda
- defining nursing document
- Role re-design workshop - lets do it
- Maintenance info
- DDD. October manager rota
- The circulator ...
- Donate as you spend
- essence of care
- Surgical Directorate - philosophy and objectives from SAU wall
- From SAU - patient information - info for staff
- Trust list of vacancies
- Job description pack
- Info leaflets found in surgical wards interlink corridors
- GGG. Sisters' meeting minutes
- Agenda
- Original notes
- JJJ. Sisters meeting notes
- Health and Safety notices
- Agenda
- IWL - briefing for managers
- STAG news - draft
- Patient and staff experience day

All other additional supporting documents retrieved during fieldwork

1. 1983 - GNC practical exams for student nurses
2. A25 profile
3. Division of surgery - organisational chart
4. Hospital chart: Organisation roles and structures
5. Staffing/establishment - end November
6. Directorate of surgery - patient information
7. care pathway - hernia
8. Sisters' meeting 4th December
9. Trust Talk December
10. Summary of Supporting carers in Rodingham
11. Establishment end June
12. Establishment end July
13. Info for patients undergoing surgery
14. Budget spreadsheets - pay and non pay
15. The Rodin - clinical audit news
16. End of month data sheets
17. Ward safe contents record (sheet)
18. Trust map
19. Research study on J. Hooks - info sheet
20. Letter re no places NVQ assessor

21. Patient summary booklet
22. Booklet re primary nursing
23. Photocopies of booklet on the rodins historical development
24. The Rodin- patient experience strategy
25. CNST information grid
26. Surgical Sr's meetings for
27. Deanery report
28. Sisters meeting August agenda. July minutes
29. SAM profiles of senior surgical nurses
30. New consent
31. Colo-rectal business plan
32. Complaints procedure
33. League of friends booklet
34. April Trust Talk
35. Jan Trust Talk
36. Feb Trust Talk
37. March Trust Talk
38. April Trust Talk
39. May Trust Talk
40. June Trust Talk
41. Aug Trust Talk
42. Sept Trust Talk
43. Oct Trust Talk
44. Nov Trust Talk
45. Report on the public health of XYZ city

Appendix 16: Example word processed fieldnotes.

Page from fieldnotes EEE: A night duty shift shadowing the Night Nurse Practitioner (NNP)

Met NNP - who has this new role - in the medical unit this role has been going for a number of years and it has expanded to include NP's in the daytime.

On coming on duty - because there is only me to cover all the surgical unit and the shift times start at different times, we've developed a communication sheet, so I find out the following information so that I get an overall picture of the ward situation/Directorate :

- Poorliest and post-op's
- Grades of staff (including agency)
- Those not for 222
- The bed status
- House Officer and SHO on call
- Consultant on take

Bed blocking is a major issue, sometimes have to physically walk around the wards and identify the ACTUAL number of beds occupied, it's a fire risk to not declare beds and I am responsible at night, staff naturally don't tell us head counts i.e. empty beds due home leave, on HDU/ITU - I wouldn't use these beds unless I specifically had to but I need to know patient numbers.

I am making a decision who will need help - where I have to spend most time, I'm not specifically allocated to one ward but because I came from D2 I tend to have that as my base.

The Doctor cover on night duty - the House Officer has protected sleep time from 1 a.m. to 6 a.m., the SHO is on all night - this is their normal shift - they are then off tomorrow. From 6 a.m. we can call the House Officer.

After 1 a.m. all the calls that may require referral to a doctor have to come through the surgical NNP.

Took report (or rather) worked out myself what the patients are on D2 - (see attached sheet) there is a patient with severe learning difficulties who has great dependency levels.

Continued

Appendix 17: Example page of a transcribed interview.

- Della: Can you tell me what you mean by being in charge ... you've moved up from, instead of just having a bay like today, what will the difference be in role
- Sophie: Eeh, being in charge by yourself, or being in charge and having a team as well at the weekend
- Della: Either one
- Sophie: Right ... Well ... during the week you'd be going around doing the ward round with the doctors and purely that really and just giving a hand in the teams and if they need bloods doing or drains taken out, depending on what staff are in there as well, you probably sort of move towards one end of the ward if there's more, if there's a junior D or if there's quite a poorly patient or ... then just leave the others just down, the other end ... depending on your staffing really, or if we've got an agency, a B grade agency you'll just be in that team because you know, if the rest of the ward is OK and there's D's and E's you can feel quite confident they'll be OK, I think, sometimes that doesn't happen ...
- Della: Well that's what I want to go onto after ... so on the weekend then, there's more responsibility
- Sophie: Yeah ... I think so
- Della: Why
- Sophie: Lack of doctors, doctors aren't coming round as regularly as they would in the week, the day, you can't get hold of them, sometimes there's not that support senior wise on a weekend, like you need to ask them something
- Della: Like nursing advice
- Sophie: Yeah, yeah, like you've always got your ward manager or your specialist nurses during the week ... and getting in your TCI's getting TCI's beds, which is a nightmare on a Sunday

Appendix 18: **Example page of 'tagged' interview text.**

Seniors views of Juniors.

- difficult to get them up to scratch at first
- one hadn't done any urology

Tina: Now our junior D grades have been qualified 18 months now, we had two or three starting at the same time, it was difficult at first getting them up to scratch one hadn't done urology anyway so it was all new for her, the conditions, deviations and

Della: Do you think they are specialising earlier, the juniors

- they're specialising earlier

Tina: I think so, yes

Della: Cause you and I would have had 3 lots of surgery ... in our training ... etc., etc., You chose urology fairly early on that was a major speciality in our day ... things are specialising very early for them

- current senior student - 1st surgical placement
- quite worrying

Tina: I've just had, I've got a student at the moment who finishes in March and this is her first surgical ward ... it's quite worrying really

Della: Well I've tracked the 12 new D's, I've followed through their first 6 months ... they've completed their 6 months preceptorship, I've tracked them back and the majority were from our local S of N and you'd be surprised how little surgical nursing clinical experience and I notice here a students clinical document and it doesn't say anything about surgery

Tina: It's all a bit ...

Della: Unrealistic - and depends on you to apply it to a surgical patient ... I think it's a generalist model they can actually qualify and not pass an N/G tube ... or a catheter

- can't put a drip up, or regulate it

Tina: Or worked out how to put up a drip, or regulate it

Della: So lets take for instance today, you're on a late shift and you might have, would you have a bay on late shift

Dual Role.

- I'm in charge and have a bay of patients

Tina: Yeah ... and I'm in charge of the ward

Appendix 19: Example 'Codebook' following interview analysis.

Study Leave.

Supposed to start degree
Study leave a big issue on here
I work full time

Seniors running round like headless chicken.

Got E grade after 2 years.
Came to work here after training.

How my role expanded as a junior.

In charge on late after 6 months
I can remember the shift
I had to ring a consultant

Being in charge

This weekend I'm in charge all my shifts over the weekend
I'll be in charge and have a bay
In the week it's different - ward manager here

Being in charge.

Doing ward round with Drs
Giving a hand in teams
Depends what staff are on
Doing bloods, removing drains
Move towards one end of ward - to where juniors are - leave others to it
Depends on your staffing really (agency / auxiliaries)

Weekend in charge.

At the weekend there's more responsibility
Lack of Drs, you can't get hold of them
There's not that support senior wise - no one to go to nursing wise
In the week there's the ward manager / specialist nurses
Getting the TCI's in - a nightmare
You can be in charge and have a bay
Can be lots of juniors on

Checking up on juniors.

Checking dressings
Making changes to care
Asking them have you done this

Views on juniors.

I don't think they can see that much in advance
They deal with what's going on at the time
No forward planning ability

Difference D to an E.

Can sort out the wider issues
D stuck in a bay
E you're flexible enough to float round

Associate Nurse grade

I'm an acting Associate Nurse
You have your own team
Not much difference from an E - I did these things before
But you sometimes feel a difference - you're expected to know
As an E you've always got that bit of support there
Now it's sort of hitting me
The buck stops with me
I've got to sort it out
The juniors come to you

Views of management.

Their expectations are a bit different
I think they think we can survive on a B grade
It's OK to survive on a B or 2 B's
They cut down on agency
But when you need a nurse, you need a nurse

The working life of the nurse.

Non existent
No breaks etc ... I just can't be bothered

Essence of care.

Things haven't changed really
We were doing things before - slight changes

Dependency has increased.

Definitely it has increased
More larger cases per week
Come from HDU fairly dependent
We have less seniors to manage these patients

Being in charge - with big cases / junior staff.

These patients have chest drains etc
You know the juniors don't know the care
It stops you - you have to leave your patients

Boundary Disputes.

I take blood
I don't cannulate - I've never kept it up
I don't take routine bloods - I used to
I wait for the Dr to ask,
There's an issue - one consultant said - if you take the blood you need to look up the results
I wasn't prepared to do this
I do bloods for Dr if he's busy

I used to do routine bloods - you know what to take
I do bloods if the patient looks ill
I can't prescribe
I let them know the results
I know about basic blood results

Nursing station diagnosis.

Future role expansion

It will come - prescribing
TTOs

Ringling Consultants direct.

Couldn't get TCIs in
Unhappy with management decisions - told consultant
Collaboration with consultants

The grass doesn't look greener.

I did ITU as a placement - not for me

Anguish.

Sometimes it's the dread of coming in next day
The dread of managing the dependency - especially if you have no help

Difference me as a junior and the juniors now.

You knew your way round
Did drugs with someone senior
I had no formal drug assessment
We were all the same
I didn't do any drugs in school ... it's what you learnt in placement
Some of them don't know basics - drip rates & stuff
Lou has filled the gap
They have support from both - preceptor and facilitator

Going Backwards

NNP role

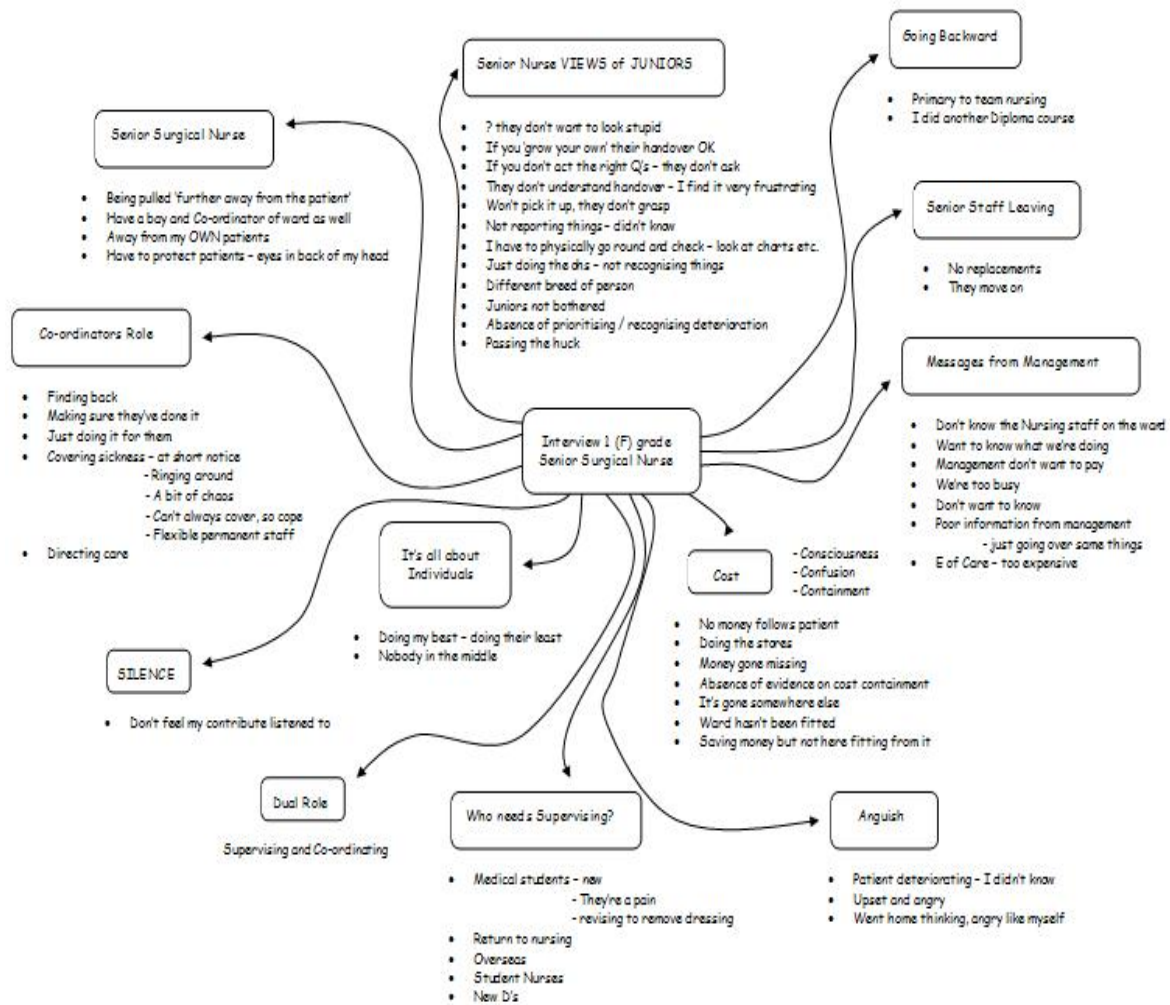
Big Cases / Few staff / Being in charge

It's experience - detecting change
Anything can happen at any time

Appendix 20: 35 themes.

- Two distinct surgical nurse cultures: Senior & Junior no real middle ground surgical nurses.
- The 'silencing' of surgical nurses.
- Boundary riders
- Hidden talents
- The grass looks greener
- Cost confusion
- Supervision / surveillance by senior surgical nurses
- Boundary disputes
- Coping with expansion demands
- Lateral role expansion
- The reality of so called specialist wards
- Knock on effect
- Anguish
- Nothings really changed
- Nursing constructing it's different to medicine
- Filling over the cracks
- Absorbing the NHS changes
- Nursing management chasm
- Expanding the working week
- The training model
- The so called 'substitution' tasks
- Defending / protecting your own patch
- Pushing the boundaries out (developing services and roles
- Limitations on my role
- Surgical nurse knows best - persistence
- Being spied upon
- Being deprived / experiencing deprivation
- Being consulted
- Horizontal violence
- Dr-Nurse issues
- Developing staff for the future
- Clash of the Titans
- Not Improving Working Lives
- Caring for colleagues
- Characteristics of surgical nurses
- Comments by surgical nurses
- What I wouldn't do
- All is not happy on the home front

Appendix 21: Interview mind map.



Appendix 22: Overview of the data analysis process.

| Analysis phases. | Cumulative ethnographic records. | The data analysis process. | Outcomes of ethnographic analysis. |
|---------------------------------|--|---|---|
| 'Descriptive' fieldwork. | Wordprocessed fieldnotes. Some numerical data. Organizational literature. | Reading / re-reading fieldnotes and context summary sheets (a process of immersion in the data). Generating descriptive concepts (Hammersley and Atkinson 1995) / sensitizing concepts (Blumer 1954) what Roper and Shapira (2000) call coding, followed by tagging text (Ryan and Burnard 2000) with these concepts. Analysing key events (Fetterman 1998). Building a codebook (Ryan and Burnard 2000) essentially summaries of the descriptive / sensitizing concepts. | Tagged wordprocessed fieldnotes. Memorandum. Codebook / index of descriptive concepts. |
| No fieldwork (Time Out). | Tagged wordprocessed fieldnotes. Memorandum. Codebook / index of descriptive labels. | Map making (Fetterman 1998) , searching for patterned regularities (Wolcott 1994), the search for recurrent and special themes in context (Leininger 1987). Comparing information sources / triangulation (Fetterman 1998). Sorting / grouping descriptive concepts into a smaller number of sets, beginning to generate themes (Clustering by conceptual grouping - Miles and Huberman 1994). NB: Leininger's (1987) 2 nd level analysis - sorting and classifying the data: Rechecking. | Codebook. Tentative cultural themes. 3 types surgical nurse: Junior, Senior, Inbetweenie. Mind maps & memorandum |
| 'Selective' fieldwork. | Codebook. Tentative cultural themes. 3 types of surgical nurse: Junior, senior, inbetweenie. Mind maps with associated memorandum. Descriptive statistics. | Reviewing new fieldnotes. Marking text for meaning and identifying cultural themes. Triangulation of information sources. Reviewing key events (Fetterman 1998). | Additional fieldnotes tagged with cultural themes. Recurrent themes grouped and conceptual maps created, showing relationships among concepts and cultural themes. |

| | | | |
|--|---|---|---|
| | <p>Additional fieldnotes tagged with cultural themes.</p> <p>Conceptual maps showing relationships among themes.</p> | <p>Creating data displays (Fetterman 1998) Map making of theme relationships and flowchart construction (Fetterman 1998).</p> <p>Negative case analysis and revising analytic assumptions.</p> <p>NB: Leininger's 3rd level analysis - identifying recurrent and special themes in context, what Fetterman (1998) calls pattern identification.</p> | |
| No fieldwork (Time Out). | <p>Additional fieldnotes tagged with cultural themes.</p> <p>Conceptual maps showing relationships among themes.</p> | <p>Reviewing all ethnographic data. Theme sorting and clustering.</p> <p>Conceptual mapping which led to theorizing Feedback on theorizing from supervisory team.</p> <p>NB: Leininger's 4th level analysis - thematic and componential formulations.</p> | <p>Draft descriptions of cultural themes.</p> <p>Tentative theory of surgical nurse role development, expansion and extension in the milieu of General Surgery Urology.</p> |
| 'Focussed' fieldwork. Ethnographic interviews | <p>Draft descriptions of cultural themes.</p> <p>Tentative theory of surgical nurse role expansion in the milieu of general surgery.</p> <p>Transcribed interviews.</p> | <p>Whole text analysis (Ryan and Burnard 2000) of the transcribed interviews - with identification of meaning related to cultural themes and tagging of transcripts.</p> | <p>Analysed individual interviews.</p> <p>Conceptual maps related to each transcribed / analysed interview.</p> |
| <u>Post fieldwork</u> a) Tidying up LeCompte and Schensul (1999) a period of serious housekeeping. | <p>Analysed ethnographic interviews.</p> <p>Conceptual maps related to each transcribed / analysed interview.</p> | <p>Continued analysis of the remaining 10 ethnographic interviews.</p> <p>Review of organisational literature and drafting remaining chapters of thesis.</p> <p>Reviewing numerical data ie monthly staffing levels, patient dependency, admission and discharge statistics, number of operations - production of descriptive statistics (Fetterman 1998).</p> <p>Content analysis (Fetterman 1998) of eg Trust newspapers.</p> <p>Whole text analysis (Ryan and Burnard 2000) of the remaining transcribed interviews - with</p> | |

| | | | |
|---|--------------------------|---|--|
| | | identification of meaning related to cultural themes and tagging of transcripts | |
| b) Interpreting the culture sharing group. | All ethnographic records | <p>Constructing a cultural inventory (Spradley 1980).</p> <p>Making sense of all the data (Cresswell 1998).</p> <p>Interpretation of the culture sharing group (Wolcott 1994).</p> <p>Making cultural and theoretical coherence (Miles and Huberman 1994).</p> <p>NB: Leiningers 5th level analysis - presenting research findings and theory formulations, identification of future lines of inquiry.</p> | |

Appendix 23: Cultural Inventory themes: Mapped by Part III Chapters.

Chapter Four: Rodingham, the Rodin and Surgical Services.

| Chapter Section. | Cultural Inventory Theme. |
|---|---|
| The City: Rodingham. | |
| The hospital (Rodin) | <ul style="list-style-type: none"> • CHI |
| A decade of Directorate developments | <ul style="list-style-type: none"> • Primary Nursing • Knowledgeable doers • Specialist Nurse services • Wards • Specialization • Care Pathways |
| Managerialism | <ul style="list-style-type: none"> • Non-clinical management • Financial issues • Cynicism • Silence • Training (cascade) • Outreach |
| The General Surgery & Urology Directorate | <ul style="list-style-type: none"> • Wards • Architectural boundaries (hospital to home) • Dependency / surgical patients • Medical Outliers • Junior Doctors • Consultant Surgeons • Medical Students |

Chapter Five: Surgical Nurse Labour Force and Conditions of Production.

| Chapter Section. | Cultural Inventory Theme. |
|-----------------------------|--|
| Introduction | <ul style="list-style-type: none"> • Staffing and Skill Mix |
| Surgical Nurse Labour Force | <ul style="list-style-type: none"> • DNM / Modern Matron • Ward Manager • Financial Issues • Bed Management • Night Duty / NNP • Junior Doctors • Training (cascade) • Skill Mix / Staffing • Primary Nurse • Pulled further from the patient • Associate Nurse • Promotion • Fledgling / New RN • Training (internal) • Anguish / stressed • Specialist Nurses • Nursing Auxiliary • Other nurses |
| Staffing the surgical wards | <ul style="list-style-type: none"> • Cycle of staff change • Clash of the Titans • Grass looks greener • Financial issues • Staffing and skill mix • Providing cover |

| | |
|--------------------------|--|
| | <ul style="list-style-type: none"> • Student Nurse • Growing your own • Training (internal) • Shift patterns • Dual roles • Acting up • Philipino Nurses • Agency Nurses |
| Conditions of Production | <ul style="list-style-type: none"> • Working conditions • Anguish / stressed • Study leave • Training (internal) |

Chapter Six: RN role development, expansion and extension.

| Chapter Section. | Cultural Inventory Theme. |
|--|---|
| From junior to senior | <ul style="list-style-type: none"> • Junior RN • Role expansion: Drug administration • Night duty / co-ordinator role • Outreach • Training • Associate Nurse • Primary Nurse |
| Shift of the day, day of the week: Co-ordinator role | <ul style="list-style-type: none"> • Ward Manager • Primary Nurse • Co-ordinator role • Staffing / skill mix • Junior RN |
| Substitution confusion / boundary disputes. | <ul style="list-style-type: none"> • Boundary disputes • Role confusion • Junior Doctors • IV drug administration |
| Going Backwards | <ul style="list-style-type: none"> • Going backwards • Role contraction • Primary nursing - team nursing - task allocation • Night Duty / NNP • Clash of the Titans • Cinderella • Surgical Nursing • Student Nurse |
| Future role aspirations | <ul style="list-style-type: none"> • Future role aspirations • Hidden talents • Prescribing • Nursing station diagnosis and prescription • Junior Doctors • Specialist Nurses • Role restrictions • Bed Management |
| Extending the working week | <ul style="list-style-type: none"> • Extending the working week • Anguish / stressed • Staffing / skill mix |

Appendix 24: **The outcome of using Hammick's (1997) REW for Ethical self scrutiny.**

The framework utilized to conduct an analysis of the ethical issues surrounding the proposed ethnographic study was Hammick's (1997) 'Research Ethics Wheel' (REW). Hammick (1997) suggests 'all health care practitioners have a responsibility to ensure their investigative work is done within the same moral boundaries that guide their routine work', she acknowledges that traditionally in health care the medical model of research (positivistic) has dominated. Currently with the increase in non-medical carers doing research and the shift to more progressive research designs, comes a need for greater ethical scrutiny, suggesting this process commences at the research proposal stage in the form of 'ethical self scrutiny'. Although Hammick's proposals are essentially focused on undergraduate research, the need for ethical self scrutiny is seen as of a greater necessity for the higher degree, this is proposed as the health carer who is a researcher in an undergraduate programme is very closely monitored, advised and guided by their academic supervisor, whereas the higher degree student is required to demonstrate initiative within an ethically responsible and accountable way as part of the process of becoming and demonstrating self management of the research. Utilizing a framework for analysing the ethical issues surrounding a research proposal is also a vehicle for the researcher to both learn more about ethical principles surrounding research and demonstrate their application to the supervisory team and those responsible for approval of the research to proceed.

The Research Ethics Wheel is essentially a comprehensive framework for 'ethical self scrutiny', it aims to help the researcher to apply the principles and process of moral reasoning to the research proposal and at all stages of the research process. Ethical Self Scrutiny is defined as the researchers responsibility to 'personally' check their research proposals, to perform checks and balances to ensure research participants are protected at all times, ensuring the researcher has considered all ethical aspects of the research process before, during and after the project. The research ethics wheel consists of 4 quarters, each with 4 segments, each segment is designed to provoke thought and reason during ethical self scrutiny. It is acknowledged by Hammick the researcher does not have to use all segments, but must consider all to exclude them from being applicable to the study.

Analysis of ethical principles using the REW:

Quadrant 1 - The PRINCIPLES of research using people.

| The Principles | Analysis |
|---|--|
| <i>The research should have a 'scientific' basis.</i> | <ul style="list-style-type: none"> • Issue being the relative merit of qualitative research, which has been criticized as biased. • Researcher having read extensively believes qualitative research is equal but different to positivist research. The researcher will demonstrate understanding of ethnography within the dissertation. • A researcher autobiography is in progress, intended to facilitate reflexivity and acknowledgement of where the researcher's attitudes and values come from and to locate 'the other' in the study as the researcher is the main data collection tool in qualitative research. |

| | |
|--|--|
| <i>Improve knowledge and understanding</i> | <ul style="list-style-type: none"> Knowledge and understanding related to Surgical Nursing is both unclear and not fully documented, the primary reason for choice of the topic. This research has not been conducted before and all literature reviews are comprehensive and up to date. The researcher is working on the basis of 'unearthing the current state of knowledge', ensuring a GAP is found, and is at this point convinced that the proposed study contains several aspects of 'originality'. |
| <i>Respect all people equally</i> | <ul style="list-style-type: none"> The researcher intends to consider the whole population that could be included in the study. The researcher is aware of the different forms of discrimination that could take place and will seek to minimize this. |
| <i>Respect the autonomy of people</i> | <ul style="list-style-type: none"> This will be addressed through the consenting process. Additionally the researcher is an experienced surgical nurse and if situations arise in the field that are felt intrusive will temporarily withdraw from the situation. |

Quadrant 2 - Duties of the Researcher

| Duties | Analysis |
|--|--|
| <i>Duty of veracity</i> (Truth telling - linked to consent) | <ul style="list-style-type: none"> There will be a need to create letters and supporting information sheets on the nature of the study, to be issued to potential participants prior to the consent process. An opportunity will need to be provided to answer any questions / queries during the consent process. |
| <i>Duty to carry out research on people giving VALID consent</i> | <ul style="list-style-type: none"> Several different consent processes will need to be used. Verbal for some, written and verbal for others Email and letter explaining study to individual subjects and their agreement may constitute consent. This will need to be followed up with an information sheet on the study. Additionally will need to gain permission from the organizations I wish to gain entry to. |
| <i>Duty to preserve anonymity and confidentiality of research participants</i> | <ul style="list-style-type: none"> It will be an essential part of the study to publish findings at different stages of the project. Deduction by readers of findings will be in the forefront of the researchers mind, therefore data presented will need to be coded and names changed to preserve confidentiality, and complete anonymity From the outset this is a qualitative study, using the ethnographic approach in one Trust hospital, the sample sizes will be small carrying with it the possibility of deductive identification of the research site... which will be addressed with gatekeepers and participants at the outset of the study. Otherwise anonymity and confidentiality related to individual wards and participants will be assured at all stages. |
| <i>Duty for each participant to assess the risk against the benefit</i> | <ul style="list-style-type: none"> Here the researcher's duty is to ensure protection of the research subjects from unnecessary investigation which cannot benefit them or anyone else (Duty of Beneficence). |

| | |
|--|---|
| | <ul style="list-style-type: none"> No risks are attached to this study in the researcher's opinion. Surgical Nursing is poorly represented in the literature and surgical nurses represent a large portion of nurses employed in a DGH, the proposed study should be of benefit to these practitioners. |
|--|---|

Quadrant 3 - NATURE of the outcome of the research

| Nature of the Outcomes | Analysis |
|---|---|
| <i>Consequences</i> | <ul style="list-style-type: none"> It is anticipated there are NO short or long term detrimental consequences surrounding the proposed study. A consequence could be mere inconvenience for participants during periods of fieldwork - but the researcher is competently familiar with prioritization in the health care setting and can easily fade into the background. |
| <i>Hazards</i> | <ul style="list-style-type: none"> No hazards are considered applicable in the study, except the mere hazard of inconvenience - to busy RNs. |
| <i>Ensuring a non-discriminatory approach to those deciding not to participate</i> | <ul style="list-style-type: none"> In the operation of gaining informed consent the researcher is aware and willing to uphold the principle of self determination for those asked to participate & who decline this offer. I am aware that the working life of health carers is increasingly demanding, this may well be a reason for declining |
| <i>Consideration of the process of the work to ensure Study Aims are achievable</i> | <ul style="list-style-type: none"> The researcher will ensure at all stages of the project that the set aims for the study are reasonably achievable. A process of constant review with the director of studies should reveal deviations from aims & their subsequent revision. |

• Quadrant 4 - Practicalities

| Practicalities | Analysis |
|---|--|
| <i>Codes of practice / the law</i> | <ul style="list-style-type: none"> I shall follow the university ethical procedures. I shall secure ethical procedures from the institution where fieldwork is proposed and follow these prior to any fieldwork. Work within my professional Code of Conduct. |
| <i>Researcher ability</i> <i>a) Intellectual</i> <i>b) Research</i> | <p>a) Intellectual</p> <ul style="list-style-type: none"> The topic of surgical nursing is one the researcher has had an extensive clinical and academic career. A CV has been constructed around this career for presentation in the appropriate places <p>b) Research</p> <ul style="list-style-type: none"> The researcher has a career history related to research in 3 separate but interrelated ways 1) Research experience - I have to date conducted 5 pieces of research 2) Research methods teaching - for the last 7 years, predominantly to registered nurses 3) Research supervisor - for nurses undertaking under- & post-graduate clinical practice research. I am a self motivated professional who will seek help & |

| | |
|--|--|
| | advice on proposed techniques & as a nurse I am aware of the professional requirement to acknowledge my limitations. |
| <i>Obligation to optimise the use of resources</i> | <ul style="list-style-type: none"> • Research is resource intensive in time & money. • Costs will change over time, in the first instance cost will predominantly be in terms of researcher time & supervisor time, which will be kept to a minimum, through my thorough preparation prior to meetings. • On the other hand the proposed study can contribute to the SNM & Uni portfolio of research therefore can be seen as an investment in the future. • Use of nursing time in the field is a key consideration as nurses are busy people - the researcher will be mindful of this situation & the investment the participants give to the study will be acknowledged in many ways. |
| <i>Scrutiny - independent of the research proposal & publications associated with.</i> | <ul style="list-style-type: none"> • Submission of draft documents and discussion of proposals with Director of Studies on an ongoing basis. • Ethical committee requirements will be followed. |

Appendix 25: Senior Nurse Meeting: Information Pack.

The General Surgery and Urology Directorate - The Rodin hospital.

A short presentation to August Sisters Meeting.

Research Working Title:
An ethnographic study of the surgical nurse role.

Letter of invite for fieldwork: Enclosure 1.

Information sheet: **Enclosure 2.**

Ethical Issues: **Enclosure 3.**

Practical Issues.

- Initial consent for fieldwork
- Interview consent (Discuss)
- Patient consent (Discuss)

Additional points for discussion:

- Discussion - researcher role within the Directorate.
- Proposed induction programme (Discuss)

Enclosure 1:

Research Study: An ethnographic study of the surgical nurse role.

Dear Surgical Nurse,

I am proposing to conduct a research study on the role of the surgical nurse within the surgical directorate. All surgical nurses within the directorate (clinical grade D - G) are being invited to participate in the research.

An information sheet on the research study is attached to this letter, please could you take time to read the information sheet carefully. Should you have any additional questions about the research please contact me on the following numbers: XXXXXXXXXX or by EMail XXXXXXXXXXXX

You are being invited to take part in the research study. After reading the information leaflet, I am seeking your consent to include you in the study. Once you have made your decision whether or not you wish to participate in the study, could you please complete the enclosed consent form and return to me in the stamped addressed envelope.

thanking you,

Della Sadler-Moore
RN / Research Student.

Enclosure 2: Information Sheet.

Research Study. An ethnographic study of the surgical nurse role.

Background and purpose of the study.

Surgical nursing is a broad term, and research studies on surgical nursing do exist, but no studies can be found that primarily studies surgical nursing in the context of role expansion. As far back as United Kingdom nursing can be traced, nurses have extended or expanded their role as a result of clinical experience, education, national and local circumstances and medical delegation. With the issuing of the UKCC (1992) document 'Scope of professional practice' came a re-evaluation of nurses' role expansion. Resulted in the development of complex systems, which on the one hand may facilitate role expansion, yet on the other restrict it. This study aims to research surgical nursing, to develop a theory of the surgical nurses' role. The study aims to contribute to nursing and health care knowledge as little is written on this topic.

What research approach and methods will be used to gather data?

This study will use an ethnographic design, which requires the researcher to gather data on normal, everyday, surgical nursing practice called 'fieldwork'. During fieldwork the researcher will work as a Registered Nurse with surgical nurses, and will gather data through observation, discussion and reviewing documents. Formal interviews will also be conducted with some surgical nurses.

How you might be involved in the study?

Initially when the researcher is observing surgical nurses at work she may ask you questions to clarify what and why you are doing something. She will make all attempts not to disturb patient care.

What role the researcher will play in the surgical directorate?

The researcher will be in the surgical wards for the purpose of collecting research data ONLY. But as a registered nurse, with a surgical background she will work with surgical nurses and be helpful in basic nursing duties. The researcher assures you that any care you deliver or discuss will not be judged.

How ethical issues will be approached?

Participation in the study is entirely voluntary. If you decide to participate you are free to withdraw at any time, without having to give a reason. You are free to ask questions at any time. All information collected from you during the course of the research will be kept strictly confidential. Any published report of the research will not identify individual nurses.

How will the results of the research be used?

You may or may not receive any direct benefit from taking part in this study. However, this study and particularly your contribution to it may help the nursing profession to understand better the role of the surgical nurse and how role expansion is achieved in practice. To this end the researcher will continue to promote surgical nursing as a specialist area of nursing practice through local and national dissemination of research findings.

Della Sadler-Moore RN - Research Nurse.

Enclosure 3: Consent Form for fieldwork.

Research study: An ethnographic study of the surgical Nurse role.

I have read the information sheet and understood the information provided.

My consent is entirely voluntary and I understand I am agreeing to the researcher conducting ethnographic fieldwork within the surgical directorate where I work. I am agreeing to the researcher observing my practice and discussing the care I provide.

If I agree to participate in fieldwork, I understand I am free to withdraw at any time, without having to give a reason why.

I understand all data will be confidential and held in an anonymised form. No data will be reported that can identify me specifically.

I also understand that should the researcher wish to conduct a formal interview with me then this will be subject to a separate informed consent procedure.

Declaration of consent:

I have read and understood the information provided and on the basis of this understanding

*I AGREE to participate in fieldwork.

*I DO NOT wish to participate in fieldwork.

(*please delete the statement that **does not** apply to your decision).

NAME (please print) _____

Signature: _____ Date of signing _____

Surgical ward number: _____

Enclosure 4: Ethical issues specific to the proposed ethnographic study.

| <i>Ethical issue</i> | <i>Applied ethical principles and practices</i> |
|--|--|
| Permission | Formal Access procedures University research committee. Wolverhampton Trust Hospitals Nursing Research Committee and Local Research Ethics committee. Surgical Directorate nurse manager. |
| Consent Respect for autonomy Non-discriminatory approach Freedom from coercion Right to refuse / withdraw Right to self determination | Nurse Manager / Nurse in charge of ward Offer to provide a short presentation at a surgical Directorate nurse manager meeting Information sheet regarding proposed study (detailed) Daily discussion prior to fieldwork in the ward Advanced notification of fieldwork dates and times Nurse participants Letter, information sheet and initial written consent document Process consenting in the field (verbal) Additional written consent for interviewing and tape recording of interview. Patients Information sheet for patients attending pre-admission clinic. |
| Anonymity and confidentiality Mindful of deduction | <i>Specifically discussed in the information leaflet</i> <i>Addressed in the consenting process</i> Data storage and protection systems in place - no entry of names into database. Coding / unique identifiers - steps to disguise identities. Taped interviews transcribed - tape erased. |
| Privacy | <i>Nurse - patient relationship (withdrawal of researcher during sensitive times)</i> Interviews conducted in private |
| Non - exploitative relationships Freedom from exploitation (part of beneficence) Co-operative, collaborative relationships Feminist standpoint | <i>Acknowledge participants contributions throughout</i> Available to provide professional academic advice as requested Don't underestimate the time required for interviews Participate in care as appropriate |

| Ethical issue | Applied ethical principles and practices |
|--|---|
| Risks versus benefits Freedom from harm | <i>Need for sensitivity to interviewees eg self disclosure and need to manage this.</i> <i>The risk of mere inconvenience to the nurse being observed.</i> Awareness of the fact that being researched can be stressful. |
| Fieldwork dilemmas | <i>Clarify lines of communication and a means of dealing with problems should they arise.</i> Maintain professional integrity. Adhere to nursing codes Awareness of role conflict - ie expert consultant, sounding board Maintain requisite distancing (balance insider / outsider role) Practical Issues Period of adjustment / orientation - induction programme. Wear uniform / name badge. |
| Supervision, advice and support. | <i>Director of Studies and second supervisor.</i> <i>Research and Development Directorate.</i> Trust research nurse. |
| Endorse an ethical stance from the outset. | <i>Behave morally at all times.</i> Establish a role that is acceptable to participants. The ethics of nursing are consistent with the ethics of research. |
| Identification and management of researcher bias. | <i>Pre fieldwork autobiography (construction and analysis).</i> Maintenance of a reflective diary whilst in the field (ongoing analysis of this). Use of member checking procedures (to verify findings). |
| Contribute to scientific knowledge. No waste of NHS resources No duplication of work Dissemination of findings | Thorough literature review reveals no previous studies Surgical nurses make up a large portion of nurses employed in the NHS / DGH are currently underrepresented. Commitment to disseminate findings. |

Della Sadler-Moore.

Appendix 26: Written surgical nurse consent for fieldwork

NB:

Please see enclosures 1-4 contained in appendix 25.

Appendix 27: Written surgical nurse Interview Consent Pack.

Research Study: An ethnographic study of the surgical nurse role.

Dear

I have been conducting a research study on surgical nursing within the surgical directorate. I am at the stage of the study where it is appropriate to conduct individual interviews, and I would like to invite you to participate in this part of the research.

Attached is a consent form providing details of the interview process for you to read prior to me contacting you to see if you would like to be interviewed.

You do not need to complete the consent form at this stage. I will contact you to see what your decision is regarding the invitation to be interviewed. If you agree to being interviewed, I will agree a convenient time and venue for this to take place. We can sign the consent form prior to commencing the interview and I will provide you with a copy of the completed consent form as a record of your personal contribution to the research study.

Should you have any queries about the research you can contact me on the following number: xxxxxxxxxx or by EMail xxxxxxxxxx.

thanking you,

Della Sadler-Moore.
RN - Research Nurse.

CONSENT FORM.

Research Study: An ethnographic study of the surgical nurse role.

I understand I am taking part in a research study on surgical nurses' role expansion. I understand I will be *interviewed in privacy* at a time that is convenient to me. I will be asked questions about my experiences of being a surgical nurse and specifically my views about role expansion.

The interview will take about 1 - 1.5 hours to complete. I also understand that Della Moore may contact me for more information in the future. Any follow up discussion would most probably be requested to feedback findings from the study and clarify any issues that have arisen as a result of analysing the data.

I understand I was selected for interview because in the process of conducting the study Ms Moore came to realise that my contribution to the study would further illustrate aspects of the surgical nurse's role.

This *interview was granted freely*. I have been informed that the interview is entirely voluntary and that even after the interview begins I can refuse to answer any specific questions or decide to terminate the interview at any point.

I have been told that the interview will be tape recorded and that the recorded information will be transcribed into a written document that will be *anonymous* and that once the transcription is complete the original tape recording will be erased. My answers to questions will not be given to anyone else and no reports of this study will ever identify me specifically. Thus *confidentiality and anonymity* will be maintained at all times.

I have also been informed that my participation or non-participation will have no effect on my relationship with the researcher during the study, or in the future. Reasons for declining to participate will not be pursued.

This study and particularly my contribution to it will help to develop a better understanding of the role of the surgical nurse and as such the researcher will continue to promote surgical nursing as a specialist area of UK nursing. Ms Moore is extremely grateful for my contribution to this study.

I understand that the results of this research will be made available to me if I ask for them and that Della Sadler-Moore is the person to contact if I have any questions about the study or about my rights as a study participant.

Date.....

Interviewees Signature

.....

Ms Della Sadler-Moore. Signature

.....

Appendix 28: Surgical Patient Consent.

Dear Sir / Madam,

Today at the **[eg pre-admission clinic]** is an additional Registered Nurse, Ms Della Sadler-Moore, who is conducting a research study on the Role of the Surgical Nurse. This involves Ms Sadler-Moore working alongside the Surgical Nurse caring for you today.

If Ms Sadler-Moore is present when you see the surgical nurse, she will make herself known to you and will check that you have no objection to her being present to observe the Surgical Nurse caring for you today. If you would prefer to be seen alone with the Surgical Nurse Ms Sadler-Moore will respect this.

Thanking you

Della Sadler-Moore.

Registered Nurse and Nurse Researcher.

Appendix 29: **Rodin's five year Strategy for Nursing (fieldwork document).**

This strategy is the focus for development of nursing and midwifery within the Trust in the next five years. It sets targets for action and responds to the change in context of care, reiterates and localises National Strategy.

The Rodin aims to be the ideal hospital, the very essence of which is characterized by the 'Caring for peoples lives'. The combination of leadership with processes and systems can 'enable' the Trust to deliver desired outcomes around clinical achievement, patient and staff satisfaction, as identified in the Patient and Staff Experience Strategies.

The trust will be a major United Kingdom hospital with clinical outcomes and performance that are seen as best in class. To achieve this requires a clear vision based on:

- Providing excellent clinical services;
- Being an excellent teaching and training provider;
- Having a strong thriving research and development base;
- Being an excellent organisation for patients, staff and community.

The strategy has eight sections, which identify the key topics for development and action:

- 1) Recruiting more nurses
- 2) Strengthening education and training
- 3) Developing a modern career framework
- 4) Improving working lives (IWL)
- 5) Enhancing the quality of care
- 6) Strengthening leadership
- 7) Working in new ways
- 8) Approach to Nursing research and development

This document provides a focus for nurses in the Trust to continue to make a difference to patient care, and emphasises the value placed upon nursing by the Trust:

1) Recruiting more nurses.

It is essential that the Trust has sufficient numbers of nurses both to maintain a good standard of patient care, and to participate fully in new clinical developments.

Over the five years of this strategy, the aim is to reduce the number of vacancies to a maximum 1% posts vacant over 3 months, and 4% of posts vacant at any one time.

We plan:

- To recruit 80% of our own students to the Trust on completion of their training by 2004.

- To have an overall improvement in nurses' satisfaction in both their role and the environment in which they work, demonstrated by an overall improvement in nurses responses to the staff survey.
- To reduce the use of agency staff
- Workload studies will determine the optimum number of staff to match activity, complexity and dependency.
- To value diversity in the workplace.
- Empowering nurse leaders to be flexible with staffing / skill mix within existing budgets, whilst ensuring safe delivery of care for patients.

2) Strengthening education and training.

The Trust recognise that for nursing to develop and nurses to develop themselves to reach their full potential, a commitment needs to be made to both education and training. This includes the development of academic knowledge, discovering new knowledge by research and training for specific roles and tasks (research is covered later in this document).

Over the next 5 years we aim to integrate theory and practice at all levels of the organisation, and to provide comprehensive educational programmes to all staff.

We plan:

- To continue with strong links and establish joint appointments between the Trust and local universities eg lecturer practitioner roles
- A comprehensive induction programme for nurses will be introduced.
- Nurses will have access to development opportunities regardless of their area of work, grade or working hours.
- 100% compliance with mandatory training.
- 100% of staff will have a PDP.

3) Developing a modern career framework.

The Trust believes nursing is a career which should be very flexible and which offers exciting possibilities. In widening the access to the progression, it is intended the framework of a modern nursing career will start from 'cadet' to Consultant Nurse, and barriers to progression should be removed where possible.

The Trust will have a comprehensive career strategy from cadet to consultant nurse.

Achieved by:

- Trust wide role reviews
- NAs have the opportunity for development and access to nurse training where appropriate.
- Implementation of a new workforce planning and workforce measurement strategy.
- We will establish more Consultant Nurse and Advanced Practitioner roles in all divisions. We will provide them with the support for these new roles.

4) Improving Working Lives.

Much of the work in this area will link to recruitment and retention. If the Trust is to expect the best from its nursing staff, we must offer the best to them and provide the resources to enable nurses to undertake their role in the most efficient and effective way. Communication is pivotal to the Trust's success in this area.

Nurses will be represented in decision-making within the Trust, and there will be a comprehensive range of facilities available to nurses.

We aim that:

- Ward nurse will control their environment, ward sister will be responsible for all aspects of the environment including cleaning and catering.
- Ward assistant role to be introduced
- Areas of excellence will be recognised through the annual multidisciplinary celebration of practice event.
- There will be a culture of recognition, respect and acknowledgement to the contribution of all levels of staff.
- Flexible working practices and employment in all areas, Senior nurses to help achieve the aims of the IWL strategy.

5) Enhancing the quality of care

Nurses have a unique role in caring for patients and an invaluable position in ensuring quality of care for all our patients.

Nurses need to play a full part in quality and clinical governance agenda, and seek at all times to improve care.

We aim to:

- Include patients in all service developments and encourage involvement where possible in all aspects of their care.
- Demonstrable excellence regarding Essence of Care benchmarks
- Practice can be demonstrated as evidence based
- Consistently high standards of nursing documentation
- All nurses will have access to clinical supervision.

6) Strengthening leadership.

The importance of leadership in achieving the Trust and the government objectives for the health service is well recognised. The roles of the modern matron and senior nurse managers will be important for the future.

Nurses will be encouraged to develop key skills and utilize them in a practical way to change the culture of the organisation and make a difference to patient care.

Our aim is:

- Ensure all ward managers complete a leadership programme
- Increase access to local and national leadership programmes
- Development of leadership programmes for other grades

- Provide a mentoring programme for all nurses
- Multi-professional leadership training - taking into account the need to move across boundaries.

7) Working in new ways.

The context of health care is changing rapidly, as is clinical practice itself. The roles of professionals are becoming more flexible and it is essential nurses are proactive in developing their own practice to ensure the best possible care and treatment for their patients.

Therefore:

- All nurses, where appropriate, will be given the opportunity to develop skills to undertake the CNO 10 key roles for nurses.
- There will be comprehensive Trust-wide policies to enhance and modernise practice.
- Specialist nurse roles will enhance the roles of general nurses not de-skill, by allowing the general nurse the opportunity to focus on developing their skills and knowledge to meet needs of the client group.
- All new roles will be designed around client / patient need rather than professional / traditional boundaries.
- New ways of working will provide continuity of care between primary and secondary care; care will be provided in the most appropriate environment.
- Where possible policies will be developed with other agencies.

8) Developing nursing research and development (R&D).

R&D offers development opportunities and therefore has an impact on recruitment, retention, development of the wider nursing context, and the potential for improving patient care by drawing on the expertise of others ...

We aim to:

- Ensure nursing input into the research agenda.
- Encourage nurses in the development of research management skills
- Promote interest in and knowledge of research
- Promote a research culture by sharing knowledge with colleagues.
- Ensure an aspect of nursing is included in the Trust's annual clinical audit programme.
- Develop journal clubs.

Appendix 30: Profile of regular ward activity (an example of three wards).

Renoir ward.

| | |
|-----------|--|
| Monday | Two all day operating lists (General, oesophageal and breast) |
| Tuesday | Alternate week an all day theatre list. Consultant pre-admission out-patient sessions on the ward. |
| Wednesday | One all-day theatre list. OPD pre-assessment |
| Thursday | Breast list Pre admission breast list on ward Alternate week ERCP in endoscopy (requiring an overnight patient stay) |
| Friday | ERCPs |
| Saturday | |
| Sunday | Large TCIs for Monday list |

Scheila ward - weekly routine.

| | |
|-----------|---|
| Monday | TCIs for Tuesday |
| Tuesday | All-day theatre list TC's for Tuesday, Wednesday, Thursday - early pre admission due to the need for pre-operative preparatory procedures. |
| Wednesday | 2 all-day theatre lists TCIs for Thursday |
| Thursday | Theatre list all day |
| Friday | |
| Saturday | |
| Sunday | TCIs for Tuesday (Major surgical cases) |

Monet ward weekly routine.

| | |
|-----------|---|
| Monday | 1 all-day theatre list TCIs for Tuesday |
| Tuesday | 1 all day theatre list TCIs for Wednesday |
| Wednesday | Theatre list pm TCIs for Thursday |
| Thursday | Theatre list all day |
| Friday | Pre admission all day 1 consultant review patients on the ward Anaesthetic assessment of patients on ward |
| Saturday | Vein radiology in x-ray department - come to ward for 4 line bandaging |
| Sunday | |

Appendix 31: Ward patient profile.

Patient composition of a 27 bed ward with 2 empty beds
(fieldnotes AA Night shift).

| Patient Age | 80's | 70's | 60's | 50's | 40's | 30's |
|----------------|------|------|------|------|------|------|
| 1 | 81 | | | | | |
| 2 | | 75 | | | | |
| 3 | | | 66 | | | |
| 4 | 80 | | | | | |
| 5 | | | 61 | | | |
| 6 | | | | 54 | | |
| 7 | | 70 | | | | |
| 8 | | | 63 | | | |
| 9 | | | | | | 32 |
| 10 | | | 64 | | | |
| 11 | | | | | 46 | |
| 12 | | 75 | | | | |
| 13 | | | 60 | | | |
| 14 | | | | | 49 | |
| 15 | | | | 54 | | |
| 16 | | | 67 | | | |
| 17 | 86 | | | | | |
| 18 | | | | | 49 | |
| 19 | | 79 | | | | |
| 20 | | | 61 | | | |
| 21 | | | | | 46 | |
| 22 | | 73 | | | | |
| 23 | | | | 55 | | |
| 24 | 82 | | | | | |
| 25 | | 79 | | | | |
| Total | 4 | 6 | 7 | 3 | 4 | 1 |

25 = 100% Average age 64.28

3 Insulin Dependent Diabetics.

2 Medical Outliers.

15 Post Op (1 x unconscious).

Burns patient with severe learning disabilities.

2 acute Biliary/Pancreatic cases.

Appendix 32: NNP First point of contact.

Subject: Out of hours call out of Junior Doctors (21.30 -07.00)

Introduction:

It is well recognised the workload of a large Acute Trust varies throughout any time period, that is during 24 hours or indeed throughout the year. It is also acknowledged acute care is continually being delivered and that this requires access to medical staff in an organised and structured way.

The role and responsibilities of the nursing staff is also considered paramount in maintaining standards of care during the whole 24 hour period.

Overall aim and objectives.

To make the most effective use of Clinical Time and ensure appropriate use of the hospital bleep system.

Aid communication between medical and other staff (ie Nurses, managers, switchboard).

To provide clear guidance as to when medical staff should not be bleeped.

To ensure that medical staff holding the bleep and those bleeping medical staff are aware of their responsibilities.

Specific Detail.

Life-threatening emergencies:

Present hospital resuscitation policy applies.

Please note a XXX call is meant for all emergencies including cardiac arrest, 'fast bleeping', major emergency, fire, flood etc.

The hospital has a policy for confirmation of an expected death where a XXX call is inappropriate.

Urgent Calls:

A nurse can always bleep the relevant doctor, via the switchboard, if in his/her opinion there is a major change in the patient's condition or distressing symptoms, which may cause the patient undue suffering before the next routine doctor's visit.

Expected deterioration in a patient's condition, or relatives request to see a doctor does not constitute an urgent call.

First dose IV drug therapy, resiting of IV cannulae and male / female catheterization DO NOT constitute an urgent call.

If a nurse requires advice on a professional basis, then they should, in the first instance, contact the Night Nurse practitioner.

Non urgent calls.

ALL BLEEP REQUESTS AFTER 23.00hrs must be channelled through the night nurse practitioner who will co-ordinate calls to avoid repetitive interruptions to the Doctors work.

The junior doctor will arrange with each ward to make a visit prior to 24.00 hrs to deal with non-urgent tasks. The junior doctor must not be contacted re non-urgent tasks prior to the ward visit. If the duty RMO is called to the wards for an urgent call at night, he/she should check with the wards / NNP for any other non-urgent tasks before returning to MAU.

After a patient FALL and there is no obvious injury, the NNP should be contacted in the first instance, or the Night Manager, for assessment and completion of the accident form.

It is expected that all IV prescription charts and IV fluid charts be checked by the DAY STAFF as being written up and complete to cover the night. Night Staff should identify any fluids required over night and leave charts to be completed on routine visits.

Appendix 33: **Surgical Directorate Retention Strategy (from fieldwork document).**

Focus of strategy: Newly qualified junior RNs
Overseas recruits

Pilot Post: Clinical Skills Facilitation 3 days per week.

Function of the post:

Supervise newly qualified Junior RNs in conjunction with the Ward Manager and identified preceptor.

Develop and implement Junior RN competency development programme with specific addendum related to the specialty surgical wards for a period of 12 months following their appointment.

Be a resource and support to the preceptor undertaking the new RNs supervision as follows:

- Undertake RNs drug competency assessment.
- Timetable essential study days to achieve competencies
 - IV
 - Venepuncture
 - Cannulation
 - Resuscitation
- Assess to ensure competence
- Participate in the standardisation of teaching packages across the Surgical Directorate.
- Undertake clinical supervision for all new RNs.
- Co-ordinate rotational placements in conjunction with Nurse Managers
 - 6 months on ward of own choice - preceptored
 - 3 months choice of 1st specialty
 - 3 months SAU
 - 2 weeks critical care / 4 weeks HDU
 - Return to base.

On completion of the 18 month programme the new RN will be ready to apply for a senior Staff Nurse post.

Benefits to juniors:

Ensured competency in areas stipulated.

Feel well supported, less likely to leave.

Succession planning into posts difficult to recruit to.

Appendix 34: Surgical Nurse Competency Development Programme¹⁴².

Section 1: General care including 11 sub sections.

Section 2: Applied section including 6 sub sections related to each of the ward specialities.

Section 3: Drug assessment (outlined in appendix 36).

With a five level assessment of competence strategy based on the work of Bondy (1983):

| | |
|----------|-------------|
| Level 0: | Unsafe |
| Level 1: | Marginal |
| Level 2: | Assisted |
| Level 3: | Supervised |
| Level 4: | Independent |

Section 1: Thre examples of the 'Eleven' core nursing topics.

| Topic area | Learning outcomes related to: |
|------------------------------|---|
| Respiratory | Anatomy & physiology of the respiratory system Airway Management Oxygen administration Humidification Pulse oximetry Physio role Oro / naso pharyngeal suction Traceostomy Respiratory emergencies Nebulizer therapy |
| Cardiovascular | Significance of observations A & P Cardiac Monitor / sinus rhythm recognition CVP lines Emergencies |
| Nutrition / Hydration | IV fluids Peripheral venous cannulae Fluid balance (siugnificance of) Fine bore feeding tube Dietician referral Diabetic emergencies Blood glucose recording Dehydration Nil by mouth / diabetic management Special diets |

¹⁴² A 45 page document in 3 colour coded sections.

The remaining competencies include:

- Elimination
- Mobility / Pressure area care
- Pain / analgesia
- Communication
- Infection control
- Pre-operative care
- Post-operative care
- Workload management

Section 2: Ward / Surgical specialty specific learning outcomes.

| Ward / Specialty. | Learning outcomes. |
|---|---|
| Renoir / General & upper GI | Specific operations eg Ivor lewis / pancreatectomy. Jaundice patient management Chest Drain management Breast care Investigations |
| Scheila / Lower GI & General | Major surgical procedures <ul style="list-style-type: none"> • Acute emergencies • Major planned surgery GI investigations Stoma management Colo rectal issues Patient discharge |
| Degas / Surgical Assessment | GP contact Patient / relative information Medical on call management Prioritisation |
| Monet / Vascular and HDU | A7P venous / arterial systems Limb observation / palpation Angiography management Major procedures <ul style="list-style-type: none"> • Amputation • AAA • Carotid endarterectomy • Emergencies Rehabilitation |
| Klimt / Urology | A&P of elimination / renal system U&E interpretation PSA Urinary catheter management & insertion Operations / care Cytotoxic drugs |

Section 3: The drug assessment competency training and assessment programme is made up of 12 objectives, broadly outlined below:

| Objective | Outline of Content |
|---|---|
| 1) To administer drugs during a drug round following agreed local and national policies and procedures | Check prescription sheet. Check drug. Arm band etc etc |
| 2) To demonstrate a knowledge of common drugs within the directorate and recognise effects and side effects | Analgesia Antibiotics Anti hypertensives Diuretics Anticoagulants Diabetic medication |
| 3) Demonstrate the management of TTOs | Procedure for obtaining Procedure for receiving FP10 |
| 4) Safety and drugs | Safe disposal Drug error Expiry dates Drug keys |
| 5) To understand safe storage of drugs | Nurse in charge role Key management |
| 6) Controlled Drugs | Ordering Storage When a drug goes missing Administration |
| 7) Role of the pharmacist | Top up system 'Out of hours |
| 8) Correct administration of injections | S/C, IM, Insulin S/C |
| 9) Accurate calculation of drugs | Drug calculations IV fluid administration |
| 10) IV drug administration | Asepsis Cannulae management Checking Flushing policy Anaphylaxis 4 administrations under supervision |
| 11) Blood transfusion | Safe collection / Checking Asepsis Reactions to / ABO 3 commencements under supervision. |
| 12) TPN administration | Central line. Storage of feeds. Aseptic procedure. 3 commencements under supervision. |

Appendix 35:

Spreadsheet regarding fledglings clinical placements.

| Student | A | | B | | C | | D | | E | | F | |
|------------------------------------|---------------------------|------|------------------------------|------|-------------------|------|-------------------------------|------|-------------------------|------|---------------------------|------|
| | Specialty | Days | Specialty | Days | Specialty | Days | Specialty | Days | Specialty | Days | Specialty | Days |
| Common Foundation Programme | Primary Care | 10 | Primary Care | 10 | Primary Care | 10 | Primary Care | 10 | Primary Care | 10 | Primary Care | 10 |
| | Acute medicine | 13 | Acute medicine (respiratory) | 13 | Acute medicine | 13 | Acute surgery (General) | 13 | Out Patients | 13 | Acute medicine (diabetes) | 13 |
| | Primary Care | 10 | Maternity | 10 | Primary Care | 10 | Maternity | 10 | Maternity | 11 | Maternity | 10 |
| | Acute surgery (General) | 31 | Acute surgery (General) | 31 | Primary Care | 30 | Day Hospital (Rehabilitation) | 12 | Acute psychiatry | 31 | Nursing Home | 62 |
| | Mental health | 32 | Nursing home | 32 | Acute urology | 32 | Dermatology Ward | 32 | Acute Surgery (General) | 31 | Primary Care | 11 |
| | Maternity | 11 | Acute orthopaedic ward | 7 | Operating theatre | 14 | Primary Care | 11 | Primary care | 11 | Dermatology Ward | 14 |
| | Acute medicine (diabetes) | 13 | Primary care | 11 | Maternity | 11 | Acute surgery (General) | 14 | Accident & Emergency | 9 | | |
| | | | Acute orthopaedic ward | 7 | | | | | | | | |
| Surgical specialty | Student A | | Student B | | Student C | | Student D | | Student E | | Student F | |
| General Surgery | 31 | | 31 | | 0 | | 27 | | 31 | | 0 | |
| Special Surgery | 0 | | 14 | | 32 | | 0 | | 0 | | 0 | |
| Operating Theatre | 0 | | 0 | | 14 | | 0 | | 0 | | 0 | |
| Totals | 31 | | 45 | | 46 | | 27 | | 31 | | 0 | |

| Student | A | | | B | | | C | | | D | | | E | | | F | | |
|------------------------|-------------------------|------|--|---------------------------|------|--|---------------------------|------|--|---------------------------|------|--|--------------------------|------|--|---------------------------|------|--|
| | Specialty | Days | | Specialty | Days | | Specialty | Days | | Specialty | Days | | Specialty | Days | | Specialty | Days | |
| Adult Branch Programme | Nursing Home | 10 | | Nursing Home | 10 | | Nursing Home | 10 | | Nursing Home | 10 | | Nursing Home | 10 | | Nursing Home | 10 | |
| | Acute orthopaedic ward | 30 | | Acute medicine (Renal) | 28 | | Coronary Care | 23 | | Acute urology | 22 | | Acute medicine (Renal) | 29 | | Acute medicine (stroke) | 30 | |
| | Primary Care | 35 | | Operating theatre | 35 | | Acute Surgery (General) | 34 | | Acute medicine (diabetes) | 35 | | Operating theatre | 35 | | Acute urology | 35 | |
| | Primary Care | 35 | | Acute Surgical admissions | 34 | | Gynaecology | 34 | | Operating theatre | 35 | | Acute trust elderly care | 32 | | Acute Surgical admissions | 34 | |
| | Acute surgery (General) | 35 | | Primary Care | 25 | | Acute medicine (diabetes) | 25 | | Primary Care | 35 | | Acute Surgery (General) | 35 | | Medical admissions ward | 35 | |
| | Acute medicine (Renal) | 27 | | Primary Care | 10 | | Accident & Emergency | 35 | | Acute Surgery (General) | 27 | | Primary Care | 35 | | Primary Care | 35 | |
| | Paediatrics | 5 | | Acute trust elderly care | 33 | | Paediatrics | 5 | | | | | Paediatrics | 5 | | Paediatrics | 5 | |
| | Intensive Care | 20 | | Paediatrics | 5 | | Primary Care | 23 | | | | | Acute Surgery (General) | 23 | | Acute Surgery (General) | 23 | |
| | | | | Medical admissions ward . | 23 | | | | | | | | | | | | | |
| Surgical specialty | Student A | | | Student B | | | Student C | | | Student D | | | Student E | | | Student F | | |
| General Surgery | 35 | | | 34 | | | 34 | | | 27 | | | 58 | | | 57 | | |
| Special Surgery | 30 | | | 0 | | | 34 | | | 22 | | | 0 | | | 35 | | |
| Operating Theatre | 0 | | | 35 | | | 0 | | | 35 | | | 35 | | | 0 | | |
| Totals | 65 | | | 69 | | | 68 | | | 84 | | | 93 | | | 92 | | |

Appendix 36: A focused literature review expanding debates in relation to some of the findings reported in this thesis.

The rise and demise of the Primary Nursing labour process.

From the locality studies conducted at the beginning of fieldwork the Rodin implemented Primary Nursing, whilst the other Acute Trust Hospitals backfilled with 'detail workers' on implementation of Project 2000. The Rodin therefore developed ward based nursing skill mix in favour of few NAs to RNs. On commencing fieldwork Primary Nursing had been in existence for more than a decade, with Senior RNs exuding to an ethos of 'innovation' and 'specialization'. What RNs specifically felt about Primary Nursing as a labour process was not the overt focus of this research, but over a two year period, clinical RNs views were that managers were causing the Primary Nursing labour process to be reverted to previous ways of working; Team Nursing and Task Allocation, which they described as a retrograde step for Nursing, and for patient outcomes.

Primary Nursing as a labour process has been the subject of much discussion within nursing in both the UK and USA. In the context of British Nursing Pearson (1988), a pioneer of Primary Nursing in the 80s reported that despite RNs being the largest occupational group in the health service, they made little contribution to decision-making, were subservient to medicine, and for 20 years had been trying to move away from task allocation and the medical model;

... to a pattern based on meeting the needs of the consumer ...
focusing on meeting the individual needs of the consumer, and on
professionalizing the nursing role to allow for autonomous practice
(Pearson, 1988, p.2).

Pearson identified a number of simultaneously occurring factors shown in Figure 1, which, when taken together called for RNs to bring about radical practice

- Re-organising work patterns so care is delivered by trained nurses, where accountability to the patient is explicit.
- Restructuring the nursing team so that the hierarchy is flattened.
- Developing a close relationship between nurse and patient, and involving the patient in planning care.
- Basing practice on a model for nursing
- Using a problem solving approach

Figure 1: Factors leading to a change in nursing (adapted from Pearson, 1988, p.6).

change. Pearson suggested to achieve change, RNs needed to occupy a role with a degree of autonomy and clear accountability to the patient, calling for the role of the clinical nurse to be re-thought;

The role of a Primary Nurse, and the method of organising care based on the concept of Primary Nursing, seems to offer an excellent opportunity to both enhance the role of the direct care giving nurse, and to create a structure through which the current trends can be put into practice (ibid., p.18).

Pearson viewed Primary Nursing as *a simple return to the original way of delivering nursing (ibid., p.23)*, but one that could have a revolutionary effect on patient care through reaffirming the central importance of the RN in health care. Stressing that although Primary Nursing was simplistic, it was a way of organising care which focused on an individual nurse being responsible for a patient throughout their hospital stay. In two experimental sites in England (Burford and Oxford) Pearson implemented Primary Nursing in what became known as Nursing Development Units (NDUs); *to help patients, increase cost effectiveness and improve job satisfaction of clinical nurses* (Pearson, 1988, p.125), but cautioned Primary Nursing [like nursing models and the nursing process] would not be a panacea of all ills, but when put together could lead to higher quality nursing care. The greatest advantage of primary Nursing Pearson indicated was that the RN could work in a professional way by being accountable for individual patient care needs, referring to the description of Primary Nursing by its' founder;

It is a system for delivering nursing care. That is all it is. It is not a solution to the problem of difference between professional and technical levels of practice and preparation, it is not a solution to the issues created by the use of practical nurses, it will not solve staffing problems nor will it increase the workload ... it is innovation that works in the real world because that is the crucible in which it was originally developed and tested (Manthey, 1973, in Pearson, 1988, p.29).

The new Primary Nursing labour process then proliferated in secondary care across England, and as a nursing development was extensively evaluated and reported on. It is not the intention in this appendix to re-open debates regarding Primary Nursing in UK secondary care, for a more comprehensive account see Ersser and Tutton (1991) or Black (1992). Having briefly introduced how Primary nursing evolved in England what is now of relevance is to shed light on forces that contributed to its 'rise and demise' as a nursing labour process.

Brannon (1990)¹⁴³ focused on explaining changes in USA hospitals at a time when Team Nursing was being replaced with Primary Nursing. Team Nursing being described as a labour process which formally differentiated nursing tasks among

¹⁴³ A paper based on a PHD thesis which used participant observation in a Californian Hospital in the latter stages of re-organising the nursing labour process (Brannon 1990). For a more extensive account of hospital re-structuring see Brannon (1994).

RNs and NAs, at the same time as workers being organised into co-operative groups. Team Nursing according to Brannon stratified RNs in a hierarchical division of labour through formally dividing tasks along the lines Braverman described as a separation of conceptualisation and routine task performance, but rather than RNs being de-skilled, they were placed in Team Leader supervisory positions. Brannon pointing out Team Nursing led RNs to view NAs as inferior workers, whilst NAs believed they did all the work, suggesting this gave NAs a *quasi professionalism*, which RNs resented. The roles of RNs and NAs in Team Nursing are outlined in Table 1.

Table 1: RN and NA roles in Team Nursing (adapted from Brannon, 1990, p.514).

| RN Role (Team Leader / Supervisor) | NA Role (Routine task performance) |
|---|--|
| <ul style="list-style-type: none"> • Reading and interpreting doctors orders • Planning patient care • Giving and receiving shift reports • Charting • Making team assignments • Evaluating NA task performance | <ul style="list-style-type: none"> • Assigned routine bedside care • Expected to carry out a multitude of less skilled tasks for patients without exercise of: interpretation, judgement or responsibility. <p>NB: NAs remain under the jurisdiction of RNs.</p> |

In response RNs shifted to Primary Nursing as the principle form of restructuring the nursing labour process, which by the mid 80s led to the replacement of NAs with RNs. The success of Primary Nursing in displacing Team Nursing Brannon (1990) suggests was a consequence of the convergence of a number of factors listed in Figure 2, and although implemented at a time when demands for health care were rising, and there was when managers had a desire

- Health Care Managers interest in achieving greater nursing productivity,
- Nursing elites interest in professionalization,
- Ward RNs interest in resolving difficulties of a sub-divided labour process on hospital wards.

Figure 2: Factors contributing to the replacement of Team Nursing with Primary Nursing (adapted from Brannon, 1990, p.515).

to cheapen labour costs, they believed it was a cheaper labour process, because Primary Nurses' were more productive through performing a broader range of nursing and nursing related tasks with little supervision. Brannon (1990) reports implementation of Primary Nursing resulted in a re-composition of the

workforce (outlined in Figure 3¹⁴⁴), through replacing NAs, the advantages to RNs

- During the late 60s and at the beginning of implementing Team Nursing the hospital labour force comprised 70% NAs and 30% RNs
- By 1986 and following the implementation of Primary Nursing the hospital labour force comprised 40% NAs and 60% RNs

Figure 3: The ratio of RNs to NAs before and after labour process changes (adapted from Brannon, 1990, p.514).

as described by Brannon are listed in Figure 4.

- Primary Nursing eliminates the contradictions of a sub-divided labour process on hospital wards.
- The re-unification of tasks removes the dilemma RNs associate with Team Nursing: that of being responsible for care produced by other workers.
- Primary Nursing has advantages for managers and physicians beyond their intention to reduce labour costs
- The augmenting of RN responsible autonomy strengthens RN accountability to those in super-ordinate positions.

Figure 4: The advantages of replacing NAs with RNs (adapted from Brannon, 1990, p.519).

Nursing labour process changes in the USA were occurring at a time when bureaucratic control in health care had increased through corporatization, and RN accountability to management had tightened¹⁴⁵ (Brannon 1990). In contrast managers saw Primary Nursing as identifying the RN [Primary Nurse] as unambiguously responsible for the organisation and performance of all tasks for each assigned patient, and the only RN responsible for completing physicians orders, giving them greater control over their work through re-unification. Although the move from Team to Primary Nursing in hospitals Brannon cautioned was a trend *neither inevitable nor irreversible* (ibid., p.519) because it had generated it's own contradictions, whereby re-unification and un-divided responsibility for nursing care brought with it greater RN job satisfaction, this was undermined by greater intensification of the labour process

With Primary Nursing the trouble is they keep including more tasks and heavier assignments and you have to do everything ... can't take on much more (ibid., p.520).

¹⁴⁴ Brannon (1990) suggesting Team Nursing, where the RN was in the role of supervisor was the *basis for professionalisation*, whereas Primary Nursing was *professionalised nursing* as a result of reversing the percentage of NAs to RNs.

¹⁴⁵ through eliminating bureaucratic rules inherent in Team Nursing [a sharply demarcated sub-division of tasks].

Brannon also suggested the labour cost advantages of Primary Nursing to management could be undermined by wage differentials between RNs and NAs, because increased intensity of the labour process, and increased RN empowerment led RNs to demand higher wages. The extent to which RN wages were greater than NAs Brannon suggested could be a management incentive to re-introduce the NA, a prediction which in English hospitals is undoubtedly a factor which led to the demise of Primary Nursing in The Rodins non-critical care wards, discussed further under a subsequent theme in this appendix.

In a similar vein to Brannon, but in the context of UK health care Witz (1994) suggested, nursing changes in the 90s came not from an exclusive nursing agenda but were shaped by organisational and political contexts;

... nursings interests have always been and continue in most parts to be subordinated to more powerful groups like the medical profession and health service managers (ibid., p39).

Witz argued the re-organisation of health care brought about by Griffiths and the introduction of the internal market profoundly impacted on the direction in which change was going in nursing proposing 'post-fordism and flexibility' as useful ways of analysing trajectories for change in nursing, because nursing roles were being pushed in the direction of patient as consumer. Witz locates her analysis in the context of Walby's (1993) theory of organizational change; from fordist hierachicalised and bureaucratised structures of employment, towards post-fordist modes of governance, which Walby supported on the grounds of three trends occurring in nursing listed in Figure 5.

- Project 2000 with it's upgrading of nurse education.
- The development of Primary Nursing; a shift away from task centred division of labour to patient centred care.
- The UKCC (1992) changes to the code of conduct (which replaced task certification with principles for practice), embracing holistic versus activity based practice.

Figure 5: Three trends supporting a shift towards post-fordist modes of governance (adapted from Witz, 1994. p.41).

In advancing this perspective Witz raised an interesting point regarding consumer orientation at unit level, suggesting it was part of a more general shift to a market driven health service, raising the question;

[Is this reflective of] the spirit of development in nursing theory concerning the holistic, patient-centred mode of care or whether it dilutes or subverts the new nursing philosophy by replacing the new functionally specialised nurse practitioner, who works in partnership with the patient by a more functionally flexible RN whose

relationship with the patient is informed by a rhetoric of customer satisfaction than by a philosophy of patient advocacy and partnership (ibid., p.41).

In concluding the analysis Witz puts forward the assertion the interests of the medical profession and new managers in secondary care would be critical if 'New Nursing' was to be realized in practice, pointing to the fact NDUs were liked by managers due to their cost reduction, but opposed by some doctors due to RNs increased autonomy, observations previously borne out in accounts by Pearson (1988, 1992). The most likely trajectory of change to be tolerated according to Witz, would be an extension of RNs roles through incorporating into nursing practice routine, medically legitimated procedures, and a long way from the vision of new nursing¹⁴⁶;

... in view of trends towards the decentralization of health service finances and organization any global or collective vision of a nursing of the future is likely to be rapidly displaced by local variations in the health division of labour, within which the role of nurses will take shape, most probably in a pragmatic and ad-hoc manner. It is increasingly likely, then, that the localised power of doctors and the new general managers will become more critical than in the past in shaping in shaping the possibility and direction of change in nursing, as well as the nature of work and power relations between doctors and nurses (ibid., p42).

As seen in this study, a decade after Witz wrote the paper clinical RNs were found to be 'sandwiched between' the power of the medical profession and that of managers / government (see conclusion to Part IV of this thesis p.298).

Lundy (1996), through an analysis of fordism in relation to nursing change updates in many ways what Brannon (1990) predicted might happen in USA hospitals if nursing costs were the subject of curtailment by hospital managers;

Currently economic and social processes have resulted in a dramatic restructuring of health care organizations ... hospitals under heavy pressure to contain prices are moving rapidly towards deskilling of nursing duties as an immediate way to reduce their labour costs. ... this movement ... while at first glance may appear acceptable, the change is nothing more than a movement from Taylorism to Fordism ... (Lundy, 1996, p.163).

Writing at a time when hospitals were under pressure to contain labour costs through deskilling nursing duties, Lundy suggested on the surface this seemed OK, but below the surface argued *deskilling is a step backwards for the industry*

¹⁴⁶ with its radical re-centering of caring functions and enhanced, autonomous practitioner role (Witz, 1994, p.42).

which has serious implications for patient care (ibid., p.163)¹⁴⁷. Lundy pointing out within just two years fordism¹⁴⁸ had rapidly grown in the US health care industry¹⁴⁹, with re-structuring in cost-cutting hospitals not being done to add support to nurses but to replace RNs with unlicensed, low earning personnel. Replacing flexible RNs who provide quality care, with lesser-trained and lower paid, Unlicensed Assistive Personnel (UAPs)¹⁵⁰, described by the US Department of Labour as *a high performance workplace model*, comprising cross training, re-structuring and the use of multi-skilled workers. Lundy reports this to be a model used in routine task based manufacturing industries, and *a model un-tested in health care where the product is patient care with it's complexities* (ibid., p.166).

Regardless of this anomaly Lundy reports hospitals went ahead with re-structuring, an observation backed up by a nursing poll, where in the last two years 95% of RNs reported having skill mix changes *not for the better*. A poll which concluded most RNs felt the quality of care to be compromised due to UAPs performing inappropriate functions within the legal practice of nursing, RNs viewing UAPs as substituting for rather than supplementing RNs. Additional data from the poll is outlined in Figure 6.

- More than 30% had witnessed RN layoffs,
- 19% witnesses layoffs of Licensed Practical Nurses (LPNs),
- 50% had seen an increase in the use of Unlicensed Assistive Personnel (UAPs),
- Nursing positions were not being filled,
- RNs are spread thinner, are doing more work and for less money,

Figure 6: Additional data from Meissner and Carey 1994 survey (adapted from Lundy, 1996, p.167)

Lundy describing this as a definite movement towards fordism, and the rationale for increasing the use of UAPs being a government led report which promoted

¹⁴⁷ at a time when RNs were adjusting to the environment of Taylorism as a result of being faced with a new movement to radically change job descriptions to promote further de-skilling of the workforce (Lundy, 1996, p.163).

¹⁴⁸ which incorporates Taylorism theories but adds to them assembly line principles, and *largely turns workers into appendages of machines* (Lundy, 1996, p.166).

¹⁴⁹ It is interesting to note use of the term 'industry' in the context of health care in the USA ... a term that as yet does not seem to be very prevalently used in the context of English health care.

¹⁵⁰ who record BP but don't have the assessment skills an RN has, thus RNs are required to delegate tasks, in so doing they are removed from patient contact.

three rationales for introducing Multi-Skilled Health practitioners (MSHPs¹⁵¹) in hospitals, listed in Figure 7, each of which Lundy critiqued¹⁵².

1. Specialization had inherent limitations and in health care had been taken to its extremes,
2. There is a need for job re-design and re-structuring
3. There is a need for flexibility in cross training.

Figure 7: Three rationales for the use of Multi-Skilled Health Practitioners in hospitals (adapted from Lundy, 1996, pp.168-169).

Hospital administrators in the USA moved rapidly to adopt this money-saving, multi-skilled model, which Lundy reported; *become a kind of independent business ... rapidly growing in size and momentum* (ibid., p.167).

Lundy concluded the goals of fordism were not appropriate in hospitals, due to it being a 'low trust system' which separates conception from execution, whereby once tasks are worked out, subordinates are only required to apply them, with management believing this to be the norm. But Lundy stressed deviation from the routine occurs more often than hospital managers believe, arguing for true flexibility a 'high-trust system' is needed, where conception and execution are combined¹⁵³, suggesting;

patients today need more highly skilled care than in previous years because they enter the hospital sicker and stay for a shorter periods of time. The need of the progressive hospital is to devise economical technology and methods that will satisfy increased patient care needs. A successful strategy can only be found if the Fordist use of labour and machinery is disregarded or substantially modified in favour of more flexible forms of organization. Flexibility, the capacity to produce a range of different products at the lowest total cost, will be more important than reducing the cost of any one product to the technically attainable minimum. A flexible economy prospers by being able to produce an unforeseeably large variety of products, each in comparatively smaller numbers (Lundy, 1996, p.170).

In an overall critique of the USA trajectory regarding the RN role, Lundy pointed out;

¹⁵¹ cross trained workers providing more than one function and found in a broad spectrum of health related jobs ranging in complexity from: Non professional to professional level and Clinical and management functions (Lundy, 1996, p.167).

¹⁵² Whilst it would be useful to include the critiques from Lundy (1996) there is not the space in this appendix. I would urge all those interested in this debate to read the article in it's entirety.

¹⁵³ in such organisations they are able to adapt quickly to shifting goals because each worker is able to elaborate incomplete rules and routines and is willing to do so.

... instead of specialized machines operated by un-skilled workers, flexibility requires general purpose machines and an adaptable workforce that can adjust quickly to new patterns of organization (ibid., p.170).

and referring to the 1994 American Nurses Association (ANA) definition of RNs as 'high-performance workers', Lundy pointed out RNs have extensive patient contact and are process rather than task oriented, using continuous independent judgement to provide patient care. Proposing hospitals that will succeed in the future are high-performance work places where RNs are empowered through increasing their level of knowledge, skill and decision-making authority from which cost-containment and quality patient care will logically follow.

Returning to the UK Health Care system Gough and Humphreys (1998) at an RCN congress advised delegates *multi-skilling is here to stay*, and more recently Flint and Wright (2001) concluded [NDUs] continue to re-emerge and decline as time passes, in the case of this thesis there was a demise in Primary Nursing as a labour process in the non-critical care acute wards. For an additional theoretical discussion on post-fordism in relation to nursing, see Williams, Cooke and May, (1998, pp.89-111).

Regarding un-regulated HCAs [a term used in the UK] and un-licensed MSHPs [a term used in the USA] this labour force remain to this day, in essence 'assistants to the RN', and in the UK a labour force previously termed NAs. In relation to this study The Rodin employed few NAs in the surgical wards, but at the end of fieldwork the support worker / HCA grades were being cascaded in at a rapid pace¹⁵⁴. Although titles change, Support Worker / Health Care Assistant positions in the hospital ward nursing team remain in essence the same as when Melia (1981, 1984, 1987) conducted a study of Student Nurse occupational socialization; that of *unregulated workers with variable training*. Melia almost three decades ago (Era two as conceptualised in this thesis) raised concerns regarding the potentially powerful position of the NA, particularly when they were long standing members of the ward nursing team;

even though she is at the bottom of the hierarchy; the students rely upon her for guidance in their early days on the ward and the ward sisters make extensive use of them (Melia, 1987, p.63)

Drawing on the work of Mechanic (1968) Melia illustrated the power sources of lower participants in complex organisations;

¹⁵⁴ A decade after the three 'other' Acute Trusts in the locality studies backfilled student nurses with HCAs on implementation of Project 2000. Additionally The Rodin was at the time an Acute Trust preparing for Foundation Trust Status and nursing labour costs were under scrutiny by non-clinical managers, who invoked indirect control mechanisms to reduce these costs.

It is not useful for lower participants in complex organisations to assume and wield power and influence not associated with their formally defined positions within these organisations ... lower participants in organizations are frequently successful in manipulating the formal structure because they may have informally attained control over access to information, persons and instrumentalities ... a type of informal power often gained where there are numbers of well entrenched lower-ranking employees, and at the same time high rates of turnover among higher-ranking persons in the organisation (Mechanic, 1968, p.416. in Melia, 1987, pp.63-64).

From this observation Melia suggested routine, low prestige, technical tasks were being 'sloughed off' to NAs who were only trained in an ad-hoc way. Referring to the work of Hughes (1971) who described how in striving for professional status, nurses have tended to hand their work to 'aides and maids' (Melia, 1987, p.307), whilst nurses take over 'cast off' medical work, a trend Johnson (1978) cautioned through quoting Augustus de Morgan *little great fleas have little fleas upon their backs to bite em and the little fleas have lesser fleas, and so ad infinitum* (ibid., pp.67-68).

In response to this observation Melia pointing out there was a school of thought NAs should not be referred to as nurses, because they are not qualified members of the occupational group despite studies having indicated they were doing the work, suggesting it might be more appropriate to talk in terms of 'patient work' and to decide who might be best to carry this out, rather than call it 'nursing work' as discussed by Hughes;

Some may think that nurses are a bit presumptuous in daring to describe everybody else's work in order to learn what is their own. But that is the only way to do it well ... an occupation or job consists of bundles of tasks. The thing that holds them together is that they are all done by one person and under a single name. A person, a name and a bundle of tasks ... Why are the tasks in this bundle done by the person who is called a nurse ?. For not all the tasks require the same degree of skill (Hughes, 1971, in Melia, 1987, pp.312-313).

Melia concluded the NA was seen as an important member of the nursing workforce, but their inter-changeability with the Student Nurse in hospital wards had implications for the cost of the nursing service and the future development of the occupation, quoting a colleague's work (Hardie 1978) who suggested the major trade off in nursing employment is between RNs and NAs, as found in her own study 'where there are many RNs there are few NAs and vice versa', an issue pertinent to the trajectory presented in this thesis where backfilling with variably trained and untrained HCAs was found.

As pointed out by Lundy, following the USA government introducing MSHPs these new practitioners became the focus of a new industry, which in UK health care now appears to be the same case scenario, briefly touched upon at the

close of Chapter 3 in this thesis (pp.92-94). Since submission of the thesis and the viva voce further support for this new industry has come to light. Armed with my first paper at an international conference (appendix 38), Kessler (2009) presented a paper titled 'Opening the Window: Death and the support worker'¹⁵⁵. Curiosity then led me to google: *Kessler & HCAs*, the results were comprehensive, after much reading Kessler¹⁵⁶ and colleagues seem to be the entrepreneurial spirits behind the 'gap' in the research on the position of HCAs in England, in conjunction with the Picker Institute Europe¹⁵⁷, publishing widely on support workers in different public services (Kessler 2006, Kessler, Bach and Heron 2006, Kessler 2007, Bach, Kessler and Heron 2008), from which a 'radical' framework for the provision of health care in hospitals is described by Back, Kessler and Heron (2008) which is utilized further later in this appendix. These works, and their funding sources suggest government is committed to increasing HCAs, and to proving their viability through extensive research into HCA effectiveness.

In concluding this theme this year marks the 40th anniversary of Primary Nursing (Manthey 2009a). In this paper Professor Manthey states her aim as *to set the record straight* regarding the myths that have developed about the relevance of Primary Nursing in environments with high acuity, varying skill mixes, diverse staffing patterns, and short lengths of stay, because;

some outside the practice arena have generated erroneous conclusions about Primary Nursing which have served to obfuscate the straightforward principles of primary nursing ... the concept of Primary Nursing itself is simple. On in-patient units, a primary nurse accepts responsibility for managing the care of specific patients 24/7 throughout a period of time [usually a patient's entire stay on a unit] (ibid., p.37).

To set the record straight Manthey compares three key myths that she identified from literature written over the years on Primary Nursing; more RNs are needed, it costs more, and length of stay has adverse effect on Primary Nursing. All of which she challenges, suggesting in the current climate;

The major challenges in implementing primary nursing include shorter lengths of stay, increasing numbers of part-time positions, and variable shift lengths, combined with ongoing pragmatic need to provide holistic, coordinated care for human beings. These logistical issues can best be managed by unit-based decisions arrived at through the consensus of a unified and cohesive staff (ibid., p.37).

¹⁵⁵ which shed light on the role of hospital employed HCAs in relation to death and dying.

¹⁵⁶ An academic from the business school at Oxford University

¹⁵⁷ A 30 month £309K project on support roles in secondary health care funded by the Service and Development Organisation of the Department of Health.

Three myths with the realities as reported by Manthey are outlined in Table 2.

Table 2: Correcting erroneous conclusions about Primary Nursing (adapted from Manthey. 2009a, p.37).

| Myth | Reality |
|--|--|
| More RNs are needed in order to do Primary Nursing | Skill mix on any unit should be based on patient acuity, not the care delivery system. Primary Nursing can succeed with a diverse skill mix (just as team nursing or any other model can succeed with an all-RN staff). |
| Primary Nursing costs more. | If a unit is adequately staffed for the acuity and volume of patient care in any delivery system, it is adequately staffed for primary nursing. A delivery system simply re-organises work: it does not create more work to be done. |
| Length of stay has an adverse effect on primary nursing. | A primary nurse can accept responsibility for managing a patient's care for a short episode or an indefinite stay in a long-term setting. In each case, care management is equally a manifestation of professional accountability. |

For a very eloquent discussion of the 'peculiar aspects of nursing resource management' see the most recently published paper by Manthey (2009b).

Nursing as craft labour [or as a profession].

Literature continues to evolve on nursing professionalization / nursing as a profession, literature which was considered when writing up the thesis, but as stated in the opening to Part I (p.25) preference was given to the sensitising concepts discerned from Braverman for interpreting the ethnographic findings. During the interpretation process a range of perspectives were revealed regarding nursing outlined in Figure 8. To explore further the different ways

| | | |
|---|-------|--------------|
| Student Nurse | ..... | New RN |
| Junior RNs | ..... | Senior RNs |
| Managers | ..... | Clinical RNs |
| NAs | ..... | RNs |
| Figure 8: Differing perspectives found in this research project. | | |

nursing can be viewed, the concepts 'occupational segmentation' and 'craft labour' are now utilized.

Melia (1981, 1984, 1987) used the analytical device 'occupational segmentation' to interpret ethnographic findings on Student Nurse occupational socialization, the results of which led her to conclude;

nursing as an occupational group comprise a wide and diverse range of personnel, regarding their level of education, the type of work they carry out and the amount of responsibility they shoulder (Melia, 1987, p.161).

Regarding the wider occupational group of nursing Melia used Carpenters (1977) threefold classification shown in Table 3, adding to this a fourth group, the

Table 3: Three main groups in nursing (Carpenter 1977, adapted from Melia, 1987, p.163).

| The main groups in nursing. | Description. |
|-----------------------------|---|
| <i>New Managers</i> | Emerged following the introduction of Salmon. |
| <i>New Professionals</i> | A small group of CNS's, independent of line managers who stand outside the hierachical structure of nursing, who cream off more complex parts of nursing and in the UK were formalized with the proliferation of post basic course in the 70's. |
| <i>Rank and File</i> | Who form the mainstream of nursing. |

Academic Professionalizers, describing these as;

... found in academic circles and removed from patients, their work is mainly research and teaching, nevertheless seek autonomy for nursing by educating 'basic' or 'primary' care had status, and placing less emphasis on medically prescribed work, their aim being to promote a style of nursing based on nursing theory (Melia, 1987, p.163).

Melia then linked the four groups with the analytical device 'segmentation', to reveal a straight divide between nursing education and nursing service, suggesting each segment was *canvassing a different approach to nursing work, and creating competition for curriculum control (p.166)*, indicating ambitions for nursing were being voiced by the more powerful and active members of each segment¹⁵⁸. For Student Nurses' this divide led them to experience two versions of nursing outlined in Figure 9, and requiring them to co-exist and negotiate their way through their training. Additionally students on registration were

¹⁵⁸ With the service segment being about getting the work done, and the academic sector focusing on laying claims to academic and professional status.

- **The education version:** Idealized, professional / independent, practice being based on professional judgement and as such was a long-term product.
- **The service / hospital version:** Aligned to a pragmatic/ workload approach, where nurses were competent but compliant.

Figure 9: Two versions of nursing experienced by Student Nurses' (adapted from Melia, 1987, p.161)

anxious about joining the ranks of nursing, because they felt their work was different to that of the Staff Nurse, a similar finding reported by new RNs in this study (pp. 210-217), and could be seen as an indicator 'nursing is going backwards', described by senior RNs in this study. Almost 30 years have passed since Melia described the service-education divide, a divide useful for reflecting on changes that have occurred in provision of nurse education since it was initially described by Melia in the early 80's.

In the era before Project 2000, the divide between education and service was in the opinion of the architect of this thesis fairly non-existent, and a view in contrast to that of Melia. In defence of this assertion, the majority of pre and post registration nurse education was provided in hospital based Schools of Nursing, externally validated and monitored by nursings' government body. Very few HEIs provided pre-registration nursing degrees, whilst slightly more provided post-registration programmes for RNs wishing to pursue additional academic qualifications or Primary Care specialist courses. Table 4 provides an overview of Service and HEI nurse education pre Project 2000.

The pre Project 2000 Student Nurse position in the hospital nursing labour force as explored by Melia, led her to question whether the Student was following a true apprenticeship¹⁵⁹, because they worked less frequently with trained staff than with other students and NAs. Melia concluded students were somewhat different to apprentices, and whether the apprenticeship worked through reference to the notion degraded work;

As technology has advanced the labour processes have become at once sophisticated and tedious. Sophisticated because of the technology and detailed planning involved for one set of workers, and tedious because the work is broken down into small parts which require little or no skill to perform. 'Scientific managers' undertake the creative part of the process, whilst workers at the operational levels are left with the tedious aspects of work ... the literature reveals the worker becomes alienated from the product of his labours and his work is as such deskilled or degraded ... the place of the craftsman in this process disappears (Melia, 1987, p.77).

¹⁵⁹ where an apprentice 'constantly' works with, and learns from a craftsman. Pointing out the RN should be the students craftsman, on whom the student can role model their behavior.

Table 4: The provision of education for RNs pre project 2000.

| The Service Segment (Hospital) | The 'Higher Education' Segment (University / Polytechnic) |
|---|---|
| Pre-Registration Student Nurse: 146 week curriculum. Theory and practice delivered in the on-site hospital. Pre-Registration Pupil Nurse: 2 year programme. | Pre-registration 'elite' degree programmes eg Manchester University. |
| Post-Registration RN: ENB accredited courses Clinical (long) courses. ENB statemented (short) courses. | Post Registration RN: DPSN (University of London accredited). Nursing Degree. Other health related degree programmes. Certificate in Education (Nurse Tutor course). Clinical Teacher course (RCNT). Specialist Recordable qualifications: District Nursing. Health Visiting. |
| Nurse Education teaching staff. Director of Nurse Education Senior Tutor(s) Tutor(s) Clinical Teacher(s) | Academic staff. Lecturers Senior Lecturers |

Melia likening RNs to Bravermans' scientific managers, and students and NAs to workers, because work was planned by RNs, then carried out by the untrained. On this premise Melia proposed the Student Nurse should not be termed an apprentice, because they were not learning skills from a recognised craftsman, and because they were *working with a fragmented set of tasks which make up patient care (ibid., pp.77-78)*, from which Melia described nurse training as a 'quasi-apprenticeship'¹⁶⁰. This observation led Melia to ask whether nursing was a profession or a craft, and to suggest two alternative structures nursing might consider in the future, outlined in Table 5. The professional model would comprise a smaller more homogenous group, educated at a higher level, which would be likely to lead to more success in laying claims to nursing being a profession. In the craft model Melia suggested a drawing away from attempts to gain professional status for nursing in favour of developing nursing as a craft, which would produce;

... a nursing workforce which could operate along the lines Stinchcombe (1959) described in the construction industry, where skilled craftsmen need

¹⁶⁰ because students were learning on-the-job, learning which took place between learners [senior students teaching junior students].

little supervision because their work is guided by standards of craftsmanship, similar to professional standards (ibid., p.185).

Table 5: Two models for nurse development (Melia, 1987, pp.183-184)

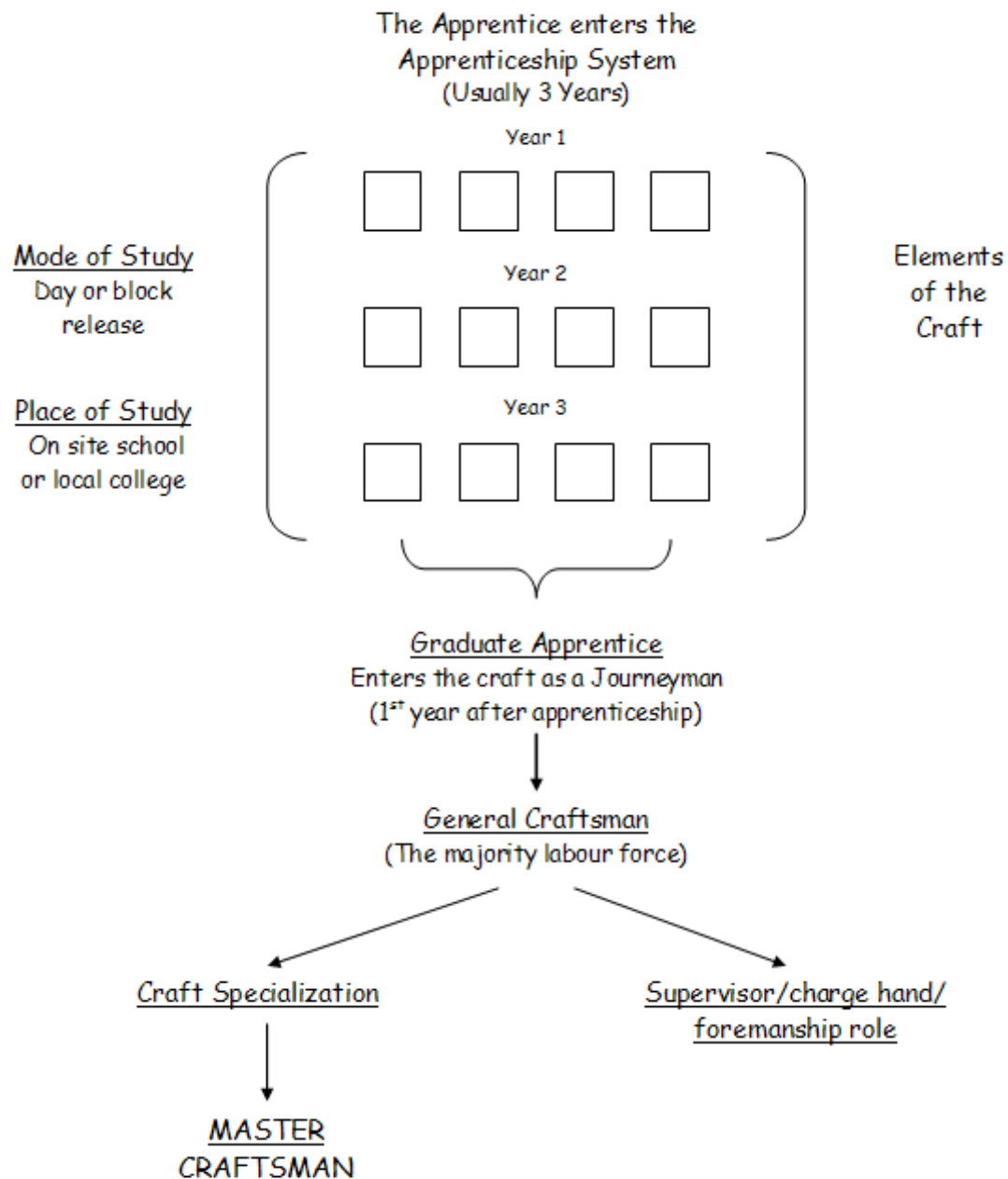
| Proposed models | Description of: |
|--------------------------------|---|
| The professional model: | Reducing the number of Student Nurses and increasing their educational standards, producing 'professional' nurses charged with effective patient care through a mixed workforce, including some grade of trained NAs. The focus of nurse education would be towards training 'scientific manager' sisters, rather than producing large numbers of RNs (many who function at a low level). |
| The craft model: | The emphasis would be on the perfection of skilled nursing work (and less stress placed on achieving a place for the occupation among the professions). Concentration on skills, with appropriate reference to theoretical ideas, would fit into the craftsman approach to nursing |

Returning to this thesis, and the focus on Braverman who was writing in the context of craft labour, it is noted Braverman never augmented a visual model of the apprenticeship to master craftsman journey. From his narrative, personal discussion with retired master craftsmen (mainly those previously in engineering), and from re-reading numerous texts¹⁶¹, it is possible to tentatively discern a model of the craft apprenticeship to master craftsman journey, shown in Figure 10.

The model demonstrates the apprentice followed a 3 year programme, during which they developed skills through rotating through the elements of the craft. On graduation the apprentice entered the craft as a journeyman, where for approximately one year the new graduate consolidated skills before being deemed a general craftsman. For the majority of craftsmen, day-to-day performance of the craft was enough, it gave them both a livelihood and a craft affiliation. Using Carpenters' classification these would be the 'rank and file' workforce. Some within the craftsman category sought career development in the form of specialization through night school or day release (HNC, HND) whilst others pursued supervisory positions. Many craftsmen rose to the position of master craftsmen, whether through additional experience, or pursuit of additional qualifications, others specialized.

¹⁶¹ including those given in the selective bibliography and Lucie-Smith (1981) and Sennett (2008).

Figure 10: A model of the apprentice, journeyman, general craftsman to master craftsman journey.



Referring to Melias description of student nurse education being a 'quasi apprenticeship', I would agree with this at the time when it was proposed, but in terms of true apprenticeship status, in the history of the RN in England, apprentice to master craftsman structures originated on implementation of the UKCC and the four national boards for education. Nurse education was housed at the time in hospital Schools of Nursing, with pre and post registration structures being in place for the RGN to progress (see discussion pp.52-53). True craft labour status for nursing, including opportunities for RN sub-specialization occurred in secondary care during the early 90s, where there was a rise in the number of Clinical Nurse Specialists and the introduction of

Advanced Nurse Practitioners, in response to the need for improved patient care.

In the Rodin when Primary Nursing was introduced it could be suggested 'true apprenticeship' conditions for future 'craftsmen', the 1:1 craftsman-apprentice learning situation was put in place, where the Student Nurse saw and was required to model their practice on a direct carer craftsman. As previously indicated Primary Nursing was implemented with the replacement monies for the student nurse labour force, often referred to as Project 2000 changes, which also involved the integration of Schools of Nursing into HEIs, and has most probably been the most likely reason for the distinctive divide that has evolved in terms of the education and service segment. Service provision of health care has dramatically changed, with many Acute Trusts becoming or applying to become Foundation Trusts, with the focus on developing the health care non-medical workforce (RNs and HCAs) being in-house competency programmes, whilst HEIs develop academically accredited programmes. Thus in the authors view has evolved a wider divide between service and education with regard to nurse education. Table 6 tentatively outlines the current provisions for nurse education between these segments.

Table 6: The provision of education for RNs and HCAs post project 2000.

| The Service segment (Hospital) | The 'Higher Education' Segment (University / Polytechnic) |
|---|--|
| Pre-Registration student nurse: Clinical Placement provision. Mentorship provision (by RNs). | Pre- registration Student Nurse RNDip Student Nurse RNBSc |
| Post registration RN: In-service training. Competency development programmes. | Post registration RN: Top up undergraduate degrees Masters degree programmes. ANP programmes. Recordable qualifications Non-medical prescribing. Mentorship programme. PGCert in Education. Specialist recordable qualifications: <ul style="list-style-type: none"> • District Nursing • Health Visiting • School Nursing et re SCPUN ... |
| HCA training / education. NVQ level 1,2,3. In-house training sessions. Competency development programmes. | Foundation Degrees; Validated by HEIs but not usually provided by them. |
| Education / Training staff. Practice placement managers. Full time in-service trainers. Clinical staff providing training sessions. | Academic staff. Lecturers Senior Lecturers Senior Management Nurse Education. |

In concluding this theme it seems appropriate to return to the recent work of Bach, Kessler and Heron (2008) who studies HCAs in the context of the modernized NHS, referring at length to three ideal models of nursing workforce provision described by Thornley (1996); Traditional, Professional and Radical. These models and their main features are presented in Table 7.

Table 7: Ideal type models of the nursing workforce (reproduced from Bach, Kessler, and Heron, 2008, p.175).

| Main Features | Traditional | Professional | Radical |
|---|----------------|--------------|------------|
| Academic training leading to RN status | Yes | Yes | No |
| Prior caring experience recognised / valued for HCAs | No | No | Yes |
| HCAs rewarded for on-the-job learning and experience | No | No | Yes |
| Mobile promotion structure | No | No | Yes |
| Curative role stressed | Yes | Yes | No |
| Task-based rather than patient / holistic-based ethos | Implicit | No | Explicit |
| Higher ratio of RNs to non-registered nurses viewed as cost effective | No | Yes | No |
| Flexible task boundaries between nurses and HCAs | Unacknowledged | No | Yes |
| Role of HCA ¹⁶² | Substitute | Relief | Apprentice |

The Radical model is of most interest here, and applicable to issues raised in this thesis regarding substituting RNs with HCAs;

This model departs from a hierarchical view of the nursing workforce based on grades linked to educational attainment. It values the experience that staff such as HCAs bring to the job, which can be utilized in an apprentice role to progress into nursing. The overall shape of the nursing workforce is not pre-defined by the profession but is much more sensitive to local managerial needs. In part because of the absence of regulation, the role of HCAs can be extended to undertake tasks within RNs jurisdiction, with tasks linked to competencies rather than to educational level (Bach, Kessler and Heron, 2008, p.174).

The radical model according to Back, Kessler and Heron, appeals to managers who wish to erode existing nursing hierarchies, and to HCAs (and their representatives);

who see [the radical model] as more egalitarian because it places a higher value on their contribution 'instead of substituting or providing relief to

¹⁶² This last line is acknowledged as having been added to Thornley (1996:172) by Bach, Kessler and Heron (2008) in this paper.

RNs, HCAs are recast in the role of apprentice (Bach, Kessler and Heron, 2008, p.174).

Bach, Kessler and Heron conclude their discussion on the future health care workforce suggesting the traditional model dominated early decades of the NHS, whereas the professional, exemplified Project 2000, whereas the radical model they describe as *typifying the modernization agenda*. It is of interest to note that the term 'apprentice' in relation to the health care workforce in the radical model is now being applied to HCAs, see last line of Table 7, and if this model does permeate throughout secondary care due to its appeal to managers, it opens the door for future RN preparation recently announced to be an all graduate endeavour, paves the way for Registered Nurses to be re-classified as professionals.

Re-modernization of Nursing¹⁶³ or New Public Management (NPM) control of Nursing.

During and following fieldwork when NHS modernization was gaining momentum, some of the findings revealed in this ethnographic study were;

- Conflicting priorities; clinical RNs and non-clinical Managers
- Cynicism by RNs to non-clinical manager control tactics
- Increased patient throughput and patient dependency
- RN work intensification
- The silencing of clinical RNs

Useful for exploring further these findings are the concepts New Public Management (NPM) and NHS modernization. Reference material used in this final theme, is, where logical to do so, presented in chronological order, with the aim of making clearer the historical context of published works, although recognising they are not reducible to a particular moment in time / given context¹⁶⁴.

The first paper is by Hewison (1999) an RN, who examined NPM in relation to 'new nursing'¹⁶⁵, suggesting NPM should be the starting point for analysing NHS structural changes and their effects on nursing. Use of the term NPM in UK policy analysis Hewison accredits to Hood (1991) who drew together a set of public sector reforms in western democracies listed in Figure 12, pointing out

¹⁶³ Re-modernization of nursing is conceptualised as Era 4 in Part I of this thesis (pp.63-73 and pp.90-93),

¹⁶⁴ A strategy proposed by Bourdieu (1998).

¹⁶⁵ The concept 'new nursing' is discussed comprehensively in Hewison (1999, pp.1379-1380).

1. Hands on professional management in the public sector
2. Explicit standards and measures of performance
3. Greater emphasis on output controls
4. A shift to the dis-aggregation of units
5. A shift to greater competition
6. Stress on private sector styles of management practice
7. Stress on greater discipline and parsimony in resource use.

Figure 12: Features of NPM public sector reforms in western democracies (reproduced from Hewison, 1999, p.1378)

the concept 'New Nursing' is used in much the same way as NPM;

in that ... it is a jumble of old and new ideas which have been assembled and may in the future be discarded ... in essence they are both forms of rhetoric, developed in different ways but with the same aim, that of increasing the power of those who seek recourse to them (ibid., p.1380)

Hewison suggested RNs and managers use different language to reflect their values and epistemologies, managers mission being to 'colonise' other workers into the New NHS. Hewison pointing out language is an important determinant as to how policy is implemented, due to because health care managers being 'skilled rhetoricians', able to persuade and influence through rhetorical means, with health policy able to be interpreted in different ways, an assertion backed up with reference to Harrison, Hunter and Pollitt (1990)¹⁶⁶ who reported NHS policy is best characterized as the outcome of Partisan Mutual Adjustment (PMA);

... no one actor or institution impose change, although several may be able to veto it and the centre possesses little direct operational control over implementation of most national policies ... The various structured interest groups adjust to each other to shape policy within a framework of accepted conventions, resulting in policy making being altered as it is implemented (Hewison, 1999, p.1381).

Local enactment of policy according to Hewison involves modification and adjustment, as was found in this thesis, when nurse education moved into HEIs and replacement of the student nurse labour force was left to Acute Trusts, three backfilled with support workers whilst The Rodin implemented Primary Nursing, which demonstrates policy can be shaped and does not always take the form its architects intend.

Hewison proposed policy should be regarded as a vehicle which promotes the ideology of a certain group, and as thus should be approached critically, pointing out the dilemma facing nursing as the exhortation of management and little

¹⁶⁶ who reviewed approaches to policy making in the NHS from 1946-1990.

nursing voice, a key finding in this study (pp.273-276), suggesting at the time the full impact of health reforms on nursing remain tentative, but it seemed likely nursing would undergo a change of identity and loose control of its work;

the relative power of nursing in policy terms has always been in inverse proportion to its size as an occupational group ... and the current situation may perpetuate this (ibid., p.1382).

In concluding Hewison acknowledged his views were somewhat pessimistic, but that it did not have to be that way referring to Trevor Clays call for RNs to unite and create a 'powerhouse for change' through local engagement with policy, suggesting RNs should become political¹⁶⁷;

... the real influence on services can be exerted at a local level through combining action and rhetoric ... re-presenting the case for nursing using the language of managerialism can help ensure nursing's voice in the policy process (ibid., p.1383).

Hewison's suggestions have in an unfortunate way come true, if the findings in this study are to be taken seriously, in all arenas where RNs engaged there was silence (pp.273-276).

Ackroyd and Bolton (1999)¹⁶⁸ focused on the development of a 'managed NHS', proposing central government policy had for two decades focused on finances and authority (in place of bureaucratic authority), whereby management structures had extended from national, through regional and district levels to the oversight of institutions delivering care. With Ackroyd and Bolton suggesting the key purpose of national organisations is control of institutional expenditure through those responsible for the use of resources, pointing out the NHS management segment is now sizeable;

Taking the employees of the NHS as a whole the ratio of managers and administrators to nurses and other carers is approaching 1:4 ... Since the early 90's the growth of the managerial cadre has levelled off, but remains true, the management and administration overhead of the NHS is substantial¹⁶⁹ ... (ibid., p.370).

leading them to ask the question What does management do ?. In answering their own question Ackroyd and Bolton reported;

¹⁶⁷ Referring to the work of Lipsey (1980) who suggested nurses should get political through becoming 'street level bureaucrats' and actively frame policy for local needs.

¹⁶⁸ Empirical research in an Acute Trust Hospital gynaecological service.

¹⁶⁹ Ackroyd and Bolton (1999) refer to figures from Harrison and Pollitt (1994) who by the late 80s found more than 60% of Senior Managers in General Manager positions in the NHS were former finance and administrative staff, add to this 10%, managers recruited from outside the NHS results in only a minority of managers who were former health professionals.

... management of itself, of course, does not make any contribution to output. The rationale for management is usually held to reside in the ability of this group to configure (or reconfigure) the use of available resources more efficiently. In the case of the NHS management, this group must be able to show that because of their utilisation of resources ... a more productive or efficient outcome occurs (ibid., p. 370),

These general indicators were reported as; increased numbers of patients being treated, simultaneously with a reduced number of carers, a finding borne out in this study. In defense of their assertion, Ackroyd and Bolton identified managements efforts to achieve these effects had not been examined in detail¹⁷⁰, describing two different accounts of the effect of NPM on the work of RNs extant in the literature. The first relates to RNs traditional autonomy being preserved, where Senior RNs are of the view new managers had not significantly encroached on their autonomy, backing this up with the work of Robinson (1992) who postulated the 'black hole theory of nursing';

Managers and government are ignorant of what nurses do and what they might wish to do, to the extent of regarding the actual practice of nurses as a black hole: as something to be studiously avoided (in Ackroyd and Bolton 1999, p.372).

The second account is where public sector managers use techniques similar to early proponents of Scientific Management¹⁷¹, which Ackroyd and Bolton suggest is a hypothesis with merits, and although applied to the work of nurses in some times and places, there is little evidence it has been adopted in the UK;

whatever expertise they have, few NHS managers can claim a knowledge of nursing tasks which would enable them to redesign the work so that it can be done more efficiently (pp.372-373).

The more plausible account regarding management control proposed by Ackroyd and Bolton is that managers are adjusting skill mixes through increasing the number of untrained (grade dilution), aimed at reducing costs through reducing the number of relatively expensive RNs, although point out there is little evidence to support this being a general policy adopted by NHS managers, suggesting they use other tactics like; employing increasing numbers of RNs on non-standard contracts, or using bank and agency staff. Neither of these tactics Ackroyd and Bolton concluded come under the remit skill dilution, because RNs continue to make up the labour force, and a tactic that does not

¹⁷⁰ arguing too much concern for cost reduction and the neglect of the re-organisation of service provision, including – inter alia work intensification is a substantial error.

¹⁷¹ referring to the work of Pollit (1993) which criticizes neo-tayloristic tendencies of contemporary NHS and also the work of Walby (1994)

constitute de-skilling, because the employees are still part of the RN proportions on wards, an observation which led them to ask;

[If] NHS managers do not directly control the work of nurses through controls of performance, [how do they], and with what effectiveness they actually achieve control of their conduct ? (ibid., p.374),

Ackroyd and Bolton describe managers' as the controllers of the supply of 'other things' essential to the provision of health care, the crucial one being patient numbers, thus managers control the context in which RNs carry out their work and exercise their professional judgement. Through increasing the number of patients RNs see, managers indirectly adjust the time available to treat the patient, setting the key conditions in which RNs work;

inducing them to work a great deal harder ... unless they are prepared to disregard their own ideas and standards about what is appropriate to adequate hospital care (ibid., p374).

To this end Ackroyd and Bolton explored the mechanisms by which output increased through work intensification in the NHS. It is not the intention here to report in detail the findings from this study, but in summary they found increased patient admissions, staff reductions and considerable work intensification, which RNs were acutely aware of;

They keep increasing the surgical lists, like we haven't already got enough to do, I tell you, some days I feel like saying; 'What the hell. Let them get on with it, I'm too knackered to care any more'. (ibid., p.379).

With marginal reductions in staffing levels adding greatly to nursing workload and responsibilities;

On weekends the staffing levels have been cut to the bone. Last saturday, I went home on my knees. And weekdays are often no better. It only takes some-body to be off sick or a complicated case to come back from theatre, and the place is thrown into chaos ... except of course that it never gets to complete chaos, because we all rally round to make sure it doesn't get to that (ibid., p.379-380).

Thus Ackroyd and Bolton noted management had not taken direct control of RN work, but had gradually extended control over key parameters of RN activities, leaving RNs with the capacity to organize themselves and to exercise discretion, but under conditions out of their control, conditions which had become increasingly adverse. In concluding their analysis Ackroyd and Bolton suggested that it doesn't seem that managers have taken steps to directly control nurses work, but have relied on manipulating the context of RN work, combined with the

continuation of traditional RN autonomy¹⁷². Although managers had re-set the parameters of nurses work by increasing the number of patients and reducing nursing time to care for them, in the context of medical 'production' containing some highly routinised activities and predictable outcomes, there continues to be significant elements of variety which require the capacity for high levels of discretion in deciding what to do and high skill in doing what is required. The increased numbers of patients increased some of the attendant risks of hospital care, for this reason Ackroyd and Bolton suggested;

... patients are in hospital for the period of their maximum vulnerability and likely need for care ... continued vigilance concerning the response of patients to treatment is essential to the high throughput regimes of care being innovative in hospitals ... in these situations poorly trained nurses with inadequate skills would often greatly increase the dangers ... (ibid., p.383).

pointing out that as the number of patients increases so does the need for RNs with higher levels of skill and commitment for this to be successful. In their final conclusion Ackroyd and Bolton suggest;

Caught as they are in a vicarious crossfire of competing demands from management to give care for more patients in increasingly adverse circumstances and from patients themselves to respond more quickly and effectively to their individual needs ... huge demands are placed on the nurses capacity to deliver care their own professional training and professional practice suggest is necessary (ibid., p.384).

Also published before the NHS Plan and before this study was conducted is a study by Adams et al (2000) on nursing skill mix changes and work intensification, conducted in eight trusts in England, from which they identified different forms of skill mix changes listed in Figure 13.

Adams et al suggesting not only were some RNs assuming more managerial and wider clinical remits, they were also experiencing new ways of working due to service re-structuring and skill mix initiatives, leading RNs to have to supervise larger numbers of support staff and students, giving rise to *a supervisory load in the absence of compensatory labour in Acute Trusts*. In the Rodin, this was not the case regarding student nurses, because they were absorbed easily into the day-to-day workload of Senior RNs in the non-critical care wards, although what was a burden were the overseas, return to practice and others on placement in the acute wards.

¹⁷² because it is in the interests of managers to leave the professional autonomy and accountability of the RN in tact, but results in work intensification, pointing out there are reasons to believe this will be the regime for the foreseeable future.

1. **Multiskilling:** where both professional and non-professional care staff undergo additional training, to produce a broader range of care skills.
2. **Role-extending:** RNs take on new tasks from another professional group.
3. Increased **Managerial functions**.
4. Development of **specialist roles:** within a particular discipline eg the CNS in orthopaedics or critical care.
5. Changes related to **nursing grade dilution:** where there is employment of more HCAs and fewer RNs (what many in the health services associate with the term skill-mix changes).

Figure 13: Different forms of skill mix changes (adapted from Adams et al., 2000).

The negative effects of skill mix changes revealed in the study are listed in Figure 14, with Adams et al concluding

- **Enlarged job remit:** unrelenting workload pressures on RNs
- **Resource constraints and quality concerns:** Here RN's felt they are doing more with less ... coping with greater workloads, restricted budgets, fewer staff and therefore less work times. Tight resources create concerns regarding the quality of care and patient welfare.
- **Working relationships:** change in nursing roles affected the quality of work relationships. With the increased skill mix dilution and greater supervisory responsibility ... many RNs felt isolated and strained.

Figure 14: The negative effects of skill mix changes (adapted from Adams et al., 2000).

... managers felt the value of nursing was often marginalized, with several alluding to a perceived obsession with quantifying service provision rather than valuing staff (p.548)

Due to ward re-configuration and skill mix changes many nurses felt under pressure to work with patients requiring care they neither had the skills or confidence to provide in wards that had merged and become multi-speciality. In concluding Adams et al indicated RNs reported there were multiple negative outcomes associated with skill mix changes, including being required to juggle additional role functions on top of pre-existing clinical responsibilities, findings also reported in this thesis under the theme 'dual roles'.

The data in this thesis was gathered, interpreted and reported during the period after launch of the NHS Plan, in what has become known as the NHS

modernization era. Melia (2005) in an ESRC fellowship¹⁷³ focused on UK NHS modernization in terms of 1) NHS Plan, 2) subsequent reports and 3) the EWTD;

to understand the place of nursing in the new NHS from the perspectives of service provision, education and professional regulation.

Opening the ESRC report Professor Melia quotes a Sunday Times headline *nursing to take on doctors role*, and acknowledges that these concerns raised in the media sum up the challenges associated with NHS modernization, which seek to provide high quality care through multi-professional teams, simultaneously with trying to become a model employer¹⁷⁴. Melia reports she found evidence of the NHS Plan vision being a reality in practice, with workforce planning and recruitment / retention of health care staff acknowledged as central to NHS reforms, in the form of the three pay modernisation agreements¹⁷⁵.

For nurses the introduction of Agenda for Change (AfC) placed all health care workers on one pay spine, which raised their expectations, not all of which can be met, which in the long run could cause more problems than it solves as there are winners and losers (ibid., pp. 20-21).

Placing all health care workers on a single pay spine Melia suggested could lead to local pay bargaining which would fit in with the English internal market ethos and the move towards Foundation Trusts¹⁷⁶, a finding corroborated in the period following fieldwork in this study, where through ward reconfiguration, and job description revisions AfC band 6 and band 7 RNs (Associate and Primary Nurses) were offered employment security only if they agreed to a grade reduction.

Melia pointing out NHS reforms were presented as a solution to problems in the workforce through an ethos of 'working smarter and differently', and brought about through re-designing services which emphasise the use of care pathways and a re-drawing of traditional boundaries between health care professionals.

¹⁷³ Nursing in the new NHS: A sociological analysis of learning and working an ESRC fellowship with five objectives, objectives one and two being pertinent to this discussion:

1. To discover how the different parties (clinicians, managers of nursing service, HE, professional bodies) respond to and develop DOH proposals for NHS modernization
2. To analyse the conceptual and practical issues raised for nursing by implementation of the NHS Plan

¹⁷⁴ through developing employee skills so they can develop their potential at the same time as moving towards professionals being involved in shared learning.

¹⁷⁵ Consultant Contract, General Medical Service (GMS) Contract and Agenda for Change (AfC).

¹⁷⁶ ... a stark contrast to Scotlands approach to health care provision which Melia suggested is moving more closer towards the 1948 position.

Melia sums this up as 'the unfolding NHS plan', which has 'vested interests and unintended consequences' because;

it is only stated in general terms which lead to a non-contentious response to the reforms, but as the detail is worked out 'the broader picture is more muted and more specific and particularised attitudes towards the plan arise' (ibid., p.21).

NHS modernization being best characterized as a set of inter-related issues with a key message that Nursing, Medicine and AHP's have the same, strikingly similar workforce issues / problems, which become evident when different professions are viewed as a whole, in workforce terms these concerns relate to: Recruitment, Retention, Work satisfaction, Practice supervision, and the teaching and learning of professional skills;

How skills are passed on and safety is assured, and crucially how the service continues to be provided during the development of the NHS Plan are the central issues for all professional groups in health care (ibid., p.21).

Melia points out that after framing the problem in workforce terms this draws her to the longstanding history of the relationship of health care professions to the dominant profession of medicine, a view which supports hierarchy rather than teams, which only came to her in hindsight. New roles are being introduced in piecemeal ways as modernisation and local re-design takes place, but as Melia points out, 'new roles need to be integrated into the system already in progress (ibid:22), which will only come about through workforce planning alongside educational developments, developments in the workforce linked to educational needs, currently seen as tensions between service needs and professional interests and traditions. Melia proposing practice disciplines central issue should be to find a way to match the evidence of clinical competence and the necessary skills for good clinical practice with traditional forms of credentialing in the universities¹⁷⁷.

One of the dilemmas Melia identified being that if trying to develop consultant led service there is a need for more doctors to bring about improved service,

¹⁷⁷ in other words practice disciplines need to map university qualifications onto skills stating ...

Education is producing tomorrow's health care workforce, therefore the NHS has an interest in the education of that workforce

Pay modernisation makes a lot of changes during modernization become real and manifest difficulties and it clear the nursing profession cannot develop in relation to the reforms ... a lot about community changes and the rise in nurse led services ... The open media way and the public impression way the NHS plan was sold on re-designed services was important to its success, easier to establish a new role than change a professions culture and empower patients, indeed the link to patient benefits is often asserted rather than argued for in policy and discussion documents.

but the EWTD makes it difficult to gain enough experience in the same time period;

One has to weigh the opportunity to learn in terms of hours, also in terms of alertness during those hours. The interrelatedness of education, service and conditions of employment matters.

Melia suggesting it is not always the best option when it comes to medicine passing up some of their work for reasons of cost and shortage of nurses because they are areas already suffering shortages, which at the NATN (2004) conference Melia is quoted as stating:

the EWTD is poaching nurse roles previously done by other professionals and that they are now fishing in an already low stock pool.

Going on to declare 'who do we educate to do what? are we re-producing healthcare professionals or are we producing a healthcare workforce. Acknowledging that 'boundary blurring is necessary to develop work force skills and roles' claiming nursing is a 'clinical civil service' asked the question 'will nurses do from 5-9 what others do from 9-5?'. The question is who does what best and how do we arrange that?

If role substitution is not well thought out when nurses and AHP's take on medical work, Melia points out, it may be a case of moving the problem around, which was found in a discussion of new nursing roles (SEHD facing the future group 2003), where many in these new roles were putting in additional hours, the irony being that the intention was to reduce medical hours for reasons of overwork and tiredness, but the outcome had been to move the work strain to another part of the service.

If nurses are to pass work to HCA's, there a question of regulation of HCA's and this may lead to a more general question of the utility of eventually having just one regulatory body for all the health care workforce¹⁷⁸. Melia acknowledging it was too soon to offer final views on the place of nursing in the modernized NHS, proposing what was clear is that there will be change to the way we think about nursing services, and change in education / preparation for practice, referring to Hughes (1951) who suggested bundles of tasks which make up the work of the different professions are from time to time un-packed and re-sorted.

This is one of those times, we are not speaking of 'bundles' but of re-design, multidisciplinary teams and health care staff working

¹⁷⁸ which has it's appeal, but might be a togetherness too far for the medical profession and would re-open debates about what constitutes professional nursing.

differently, this is the language of the re-sort, the activity is much the same as that described by Hughes (Melia 2005)..

How modernization agenda affects the nursing profession, signs are this could eventually be profound as nurses (and AHP's) will not only be taking on work previously undertaken by medicine, but also giving up work to others. Nursing has a problem of defining what counts as nursing and historically is less good than medicine at giving up roles¹⁷⁹, the rhetoric in the plan being multi-professional working, presented in nursing circles as either an opportunity for new roles or extended roles in a dumped on sense. The quick fix of so called nurse led services is not an emancipation term for nursing as it is often substitution for medical work and an expression used by managers and clinicians who see either professional gain or cost savings in the use of nurses in clinics and other areas where traditionally you find a doctor which the public may perceive as a diluted service. Insofar as a general conclusion can be drawn from this ESRC study Melia stated;

there are many agendas, vested interests and unintended consequences contained within the process of modernizing. It should be remembered that these may have good outcomes, not all unintended consequences are negative. As the detail unfolds and some of what it might mean for individuals takes hold there is a risk of the plan being destabilised if not derailed as different groups respond accordingly to their own best interests as opposed to those of a service as a whole (ibid., p.22).

To conclude this final theme the work of Cooke (2006) is very pertinent¹⁸⁰. Cooke suggests modernization and change in nursing is all about 'getting more for less' from the nursing workforce, and dates back to Thatcher neo-liberal reforms of the 80s, and continued under new labour who introduced additional targets for 2003-2006, when this study was undertaken. Included in the targets was a 2% improvement in value for money, which led to increased throughput of patients at the same time as reducing capacity¹⁸¹, the effect on

¹⁷⁹ During fieldwork with AHP's Melia (2005) reports they suggested their roles were more circumscribed and based on diagnosis and intervention, therefore easier to see work that can be given up to assistants and what can be taken on from others, the boundaries between orthopaedics and podiatry being one example.

¹⁸⁰ which is in contrasted with policy pronouncements that nurses are to be empowered by recent changes, yet a study which found empowerment often implied increased responsibility and tightened control. Data was collected at a time of rapid change in the English NHS as a result of New Labour modern and dependable (DOH 1997) initiative which on one hand managerial and regulatory changes were designed to improve public protection and empower health service consumers, through tightening control of health professionals, whilst on the other RNs were offered liberation in the new NHS through being empowered with new opportunities and responsibilities.

¹⁸¹ According to Cooke (2006) NHS in-patient capacity has halved since the 80s and finished consultant episodes increased by 38% between 1990 and 1998.

RNs was faster throughput combined with higher rates of bed occupancy, also found by Ackroyd and Bolton and Adams et al, not to mention the findings reported in this thesis.

Looking back further Cooke refers to the Audit Commission (1991) report on the nursing resource, describing it as accelerating attempts to obtain 'efficiency gains' from RNs through increasing labour flexibility, which throughout the 90s was in some parts achieved via the introduction of flexible contracts; through using part time, and temporary contracts for RNs and the use of bank staff, additionally there were experiments introduced to reduce 'slack' in the nursing workforce (p.226) through imposing time flexibility via eliminating shift overlaps, more flexible forms of rostering; 12 hour shifts and annualised hours. Although these time and flexibility initiatives led to some cost savings for managers, the biggest savings would come from re-structuring the nursing workforce, one of which was the widescale introduction of HCAs, which lowered the pay floor in nursing. Findings Cooke suggested lend credence to fears expressed by some nursing writers that nursing was being re-structured along the lines of Atkinsons (1984) 'flexible firm', with a cor' of relatively secure and functionally flexible workers and at the periphery insecure, low paid workers who carry out work once regarded as the core of nursing work. Cooke refers to the work of Thornley (1996) who concluded 'the introduction of the HCA grade led to greater segmentation and inequality in the nursing workforce, it therefore follows from Atkinsons model that the core nursing workforce will be pressured to become more functionally flexible and under pressure to take on more routine managerial and medical work. Cooke pointing out Ward Sisters had become Ward Managers and taken on 24 hour responsibility for their wards, functions usually performed by middle managers. Simultaneously the new deal for junior doctors had led to RN upskilling, with little consideration of the effects of this on RNs workload as borne out in the work of Calpin-Davies and Akenhurst (1999) who identifies in most cases extended role had been without increased nursing establishment.

With regard to the strategy Liberating the Talents Cooke suggests this was sold to nurses on the grounds it was about empowering¹⁸². In this study I used the term 'cliches' to refer to the novel titles given to reports launched by the government which directly affected nursing, Cooke refers to them as 'architectural metaphor' a favourite rhetorical device in DOH policy and it's consequent HR strategy, the centrepiece being 'the skills escalator';

¹⁸² with John Reid the then Secretary of State stating he wished to encourage a new generation of entrepreneurial nurses, but in return they would need to support 'new roles and new ways of working' ... which would 'release the potential of nurses' ... with resources only being released in return for modernization.

This offers more opportunity for progression and describes a career as a succession of stages, each with its own pay band and learning requirements. Staff are encouraged and assisted to constantly renew and extend their knowledge enabling them to move up the escalator. Meanwhile roles and workloads are delegated down the escalator generating efficiencies and skill mix benefits (DOH 2002, p.8 in Cooke 2006, pp228).

In response to this Cooke suggested;

The entrepreneurial employee is offered the opportunity to rise up the escalator but how much opportunity there will be to move upwards when roles to which individuals aspire pass them on their way down the escalator remains unclear. It is hard to avoid the image of nurses running uphill in order to stand still (ibid., p.228).

The governments promises as an employer according to Cooke were;

- To reverse the decline in staff numbers
- To engage in commitment and trust building activities
- To make greater commitment to staff development

In return greater flexibility and productivity were expected from staff, Cooke suggesting this is a familiar bargaining approach in the contemporary workplace¹⁸³. The creation of a 'virtuous circle' between employers, employees and consumers leading to enhanced knowledge and skills, greater productivity and greater opportunity is too often the preserve of valedictory management literature, as seen in this study, the Rodins strategy for nursing clearly stated more RNs and more training opportunities, but the reality at clinical level was much different. In Cookes study there was overwhelming evidence of increased nursing workload (work intensification), patients going through the system were described as 'sicker and quicker', on a backdrop of grade dilution and expanded nursing roles. On a final note some RNs in the study referred to the style of management they experienced as 'seagull' management.

References.

Ackroyd, S. and Bolton, S. (1999) It is not Taylorism: Mechanisms of Work Intensification in the provision of Gynaecological Services in a NHS Hospital. *Work, Employment and Society*, **13**(2), pp.369-387.

Adams, A. Lugsden, E., Chase, J. Arber, S. and Bond, S. (2000) Skill mix changes and work intensification in nursing. *Work, Employment and Society*, **14**(3), pp.541-555.

¹⁸³ According to Thompson (2003) the employee is rarely able to keep his side of the bargain.

Atkinson, J. (1984) Manpower strategies of flexible organisations, *Personnel Management* August: 28-31, in Cooke, H. (2006) Seagull management and the control of nursing work, *Work, Employment and Society*, **20**(2), pp.223-243.

Bach, S, Kessler, I, and Heron, P (2008) Role redesign in a modernized NHS: The case of health care assistants. *Human Resource management Journal*. **18**(2), pp.171-187.

Black, F. ed (1992) *Primary Nursing. An introductory Guide*. London: Kings Fund Centre.

Bourdieu, P. (1998) *Acts of Resistance: Against the myths of our time*. Polity Press: Cambridge.

Brannon, R.L. (1990) The reorganization of the nursing labour process: From Team to Primary Nursing. *International Journal of Health Services*, **20**(3), pp.511-524.

Brannon, R.L. (1994) *Intensifying care: The hospital industry, Professionalization and the reorganization of the Nursing Labour Process*. Baywood Publishing:

Calpin-Davies, P. and Akenhurst, R. (1999) Doctor-Nurse substitution: The workforce equation, *Journal of Nursing Management*, **7**: 71-79, in Cooke, H. (2006) Seagull management and the control of nursing work, *Work, Employment and Society*, **20**(2), pp.223-243.

Carpenter, M. (1977) The new Managerialism and Professionalism in Nursing. In Stacey, M. Reid, M. Heath, C. and Dingwall, R. *Health and the Division of Labour*. London: Croom Helm.

Cooke, H. (2006) Seagull management and the control of nursing work, *Work, Employment and Society*, **20**(2), pp.223-243.

Ersser, S. and Tutton, E. eds (1991) *Primary Nursing in perspective*. London: Scutari Press.

Flint, H. and Wright, S.G. (2001) Nursing development units: progress and developments. *Nursing Standard*, **15**(29), pp.39-41.

Gough, P. and Humphreys, J. (1998) Multiskilling: Here to stay. *Nursing Standard*, **12**(31), pp.22-25.

Hardie, M. (1978) Auxiliaries in Nursing: Implications for the Division of Labour. Unpublished PhD thesis. In Melia, K. (1987) *Learning and Working. The occupational socialization of nurses*. London: Tavistock Publications.

Harrison, S. and Pollitt, C. (1994) Controlling Health professionals: The future of work and organisations in the NHS, in Ackroyd, S. and Bolton, S. (1999) It is not Taylorism: Mechanisms of Work Intensification in the provision of Gynaecological Services in a NHS Hospital. *Work, Employment and Society*, **13**(2), pp.369-387.

Harrison, S. Hunter, D.J and Pollitt, C. (1990) The Dynamics of British Health Policy, in Hewison, A. (1999) The new public management and the new nursing: related by rhetoric

? some reflections on the policy process and nursing. *Journal of Advanced Nursing*. 29(6) 1377-1386.

Hewison, A. (1999) The new public management and the new nursing: related by rhetoric ? some reflections on the policy process and nursing. *Journal of Advanced Nursing*. 29(6) 1377-1386.

Hood, C. (1991) A public management for all seasons? Public Health Administration, 69, pp.3-19. in Hewison, A. (1999) The new public management and the new nursing: related by rhetoric ? some reflections on the policy process and nursing. *Journal of Advanced Nursing*. 29(6) 1377-1386.

Hughes, E. C. (1951) Studying the nurse's work, American Journal of Nursing, 51, in Melia, K.M. (2005) Nursing in the New NHS: a sociological analysis of learning and working. ESRC Grant Number R000271191. Full Research Report.
www.esrcsocietytoday.ac.uk/ESRCInfoCentre/ViewAwardPage.aspx?AwardId=1613
accessed May 2009.

Hughes, E. C. (1971) The Sociological Eye. in Melia, K.M. (1987) *Learning and Working. The occupational socialization of nurses*. London: Tavistock Publications.

Johnson, M. (1978) Big fleas have little fleas - nurse professionalization and Nursing Auxiliaries in Hardie, M. and Hockey, L. eds *Nursing Auxiliaries in Health Care*. London: Croom Helm.

Kessler, I. (2006) Strategic approaches to support workers in the NHS: A shared interest. Leaflet from the joint work of Oxford SAID Business School and Picker Institute.

Kessler, I. (2009) *Opening the window: Death and the support worker*. Paper presented at the 27th International Labour Process Conference. Edinburgh 6-8th April 2009: Work Matters.

Kessler, I, Bach, S. and Heron, P. (2006) Understanding assistant roles in social care. *Work, employment and Society*. 20(4), pp.667-685.

Kessler, I. (2007) Using support staff in hospitals. www.sbs.ox.ac.uk/news/media/Press
Accessed may 2009.

Lipsey, M. (1980) Street-Level Bureaucracy: Dilemmas of the individual in public services. New York: Russell Sage Foundation.

Lucie-Smith, E. (1984) *The story of craft: The craftsman's Role in society*. London: Van Nostrand Reinhold Company.

Lundy, M.C. (1996) Nursing beyond Fordism. *Employee Responsibilities and Rights Journal*, 9(2), pp.163-171.

Manthey, M. (1973) Primary Nursing is alive and well in hospital. *Nursing Forum*, 9(1), p.65. in Pearson, A. ed (1988) *Primary Nursing: Nursing in the Burford and Oxford Nursing Development Units*. London: Chapman and Hall.

Manthey, M. (2009) The 40th Anniversary of Primary Nursing: Setting the record straight. *Creative Nursing*, 15(1), pp.36-38.

Mechanic, D. (1968) *Medical Sociology*. in Melia, K.M. (1987) *Working and Learning: the occupational socialisation of nurses*. London: Tavistock Publications.

Melia, K. M. (1981) *Student nurses accounts of their work and training. A qualitative analysis*. Report for the Scottish Home and Health Department. Donated anonymously to Edinburgh University Library. Accessed in person via the SCONUL system April 2009.

Melia, K.M. (1984) Student nurses' construction of occupational socialisation. *Sociology of Health and Illness*, 6(2), pp.132-151.

Melia, K.M. (1987) *Working and Learning: the occupational socialisation of nurses*. London: Tavistock Publications.

Melia, K.M. (2005) Nursing in the New NHS: a sociological analysis of learning and working. ESRC Grant Number R000271191. Full Research Report.
www.esrcsocietytoday.ac.uk/ESRCInfoCentre/ViewAwardPage.aspx?AwardId=1613
accessed May 2009.

National Association of Theatre Nurses [NATN] (2004) Report from N.A.T.N. Harrogate October 12-14th 2004 www.ino.ie/Attachment.aspx?nAttID=816 accessed May 2009.

Pearson, A. ed (1988) *Primary Nursing: Nursing in the Burford and Oxford Nursing Development Units*. London: Chapman and Hall.

Pollitt, C. (1993) Managerialism and the public sector, in Ackroyd, S. and Bolton, S. (1999) It is not Taylorism: Mechanisms of Work Intensification in the provision of Gynaecological Services in a NHS Hospital. *Work, Employment and Society*, 13(2), pp.369-387.

Robinson, J. (1992) Introduction: Beginning the study of nursing policy, in Ackroyd, S. and Bolton, S. (1999) It is not Taylorism: Mechanisms of Work Intensification in the provision of Gynaecological Services in a NHS Hospital. *Work, Employment and Society*, 13(2), pp.369-387.

Sennett, R. (2008) *The Craftsman*. London: Yale University Press.

Stinchcombe, A.L. (1959) Bureaucratic and craft administration of production: A comparative study. *Administrative Science Quarterly*. 4: pp.168-187. in Melia, K.M. (1987) *Working and Learning: the occupational socialisation of nurses*. London: Tavistock Publications.

Thompson, P. (2003) Disconnected capitalism: Or why employers can't keep their side of the bargain, *Work, Employment and Society*, 17(2), pp.359-378 in Cooke, H. (2006) Seagull management and the control of nursing work, *Work, Employment and Society*, 20(2), pp.223-243.

Thornley, C. (1996) segmentation and inequality in the nursing workforce, in Bach, S, Kessler, I, and Heron, P. (2008) Role redesign in a modernized NHS: The case of health care assistants. *Human Resource management Journal*. 18(2), pp.171-187.

Traynor, M. (1994) The views and values of community nurses and their managers: research in progress - one persons pain, another persons vision. *Journal of Advanced Nursing*. 20(), pp.101-109.

Traynor, M. (1996) A literary approach to managerial discourse after the NHS reforms. *Sociology of Health and Illness*. 18(3), pp.315-340.

Walby, S. (1993) Restructuring health professions; a case of post-fordism?, paper presented to British Sociological Association conference, in Witz, A. (1994) The challenge of nursing. in Gabe, J. Kellecher, D and Williams, G. eds *Challenging medicine*. England: Routledge. pp.23-45.

Walby, S. (1994) in Ackroyd, S. and Bolton, S. (1999) It is not Taylorism: Mechanisms of Work Intensification in the provision of Gynaecological Services in a NHS Hospital. *Work, Employment and Society*, 13(2), pp.369-387.

Williams, A. Cooke, H. and May, C. (1998) *Sociology, Nursing and health*. Oxford: Butterworth-Heinemann, pp.89-111.

Witz, A. (1994) The challenge of nursing. in Gabe, J. Kellecher, D and Williams, G. eds *Challenging medicine*. England: Routledge. pp.23-45.

Appendix 37: Paper presented at the International Labour Process Conference (ILPC).

**International Labour Process Conference (ILPC)
6-8th April 2009. Edinburgh.
Stream 2: Service Work in Hospitality and Care Industries.**

From a 'gold' to a 'silver' to a 'bronze' patient service. How management sequentially eroded the Acute Trust RN labour force. An ethnographic study*.

Della Sadler-Moore.

S.R.N., M.Ed., B.Sc.Hons. Nursing., E.N.B. A25. Surgical Nursing., Dip. Clinical Teaching., R.C.N.T., Cert.Ed.(FE)., R.N.T.

School of Health and Social Care.
University of Wolverhampton.
Telephone: 01902 518694
Email: DellaM@wlv.ac.uk.

Abstract.

This paper focuses on the theme 'nursing is going backwards' drawn from a PhD study entitled 'The role of the Registered [Surgical] Nurse in the 21st century NHS acute trust hospital (Sadler-Moore 2009). The impetus for conducting the research evolved during my academic role with Acute Trust Registered Nurses (RNs) who alerted me to their poor working conditions. A classroom experience which was in stark contrast to the published literature on hospital RN role development from which I was lecturing.

The study was conducted in one clinical directorate of an Acute Trust hospital, comprising six in patient surgical wards. The methodology was ethnography, where the researcher worked as an RN for fifteen months, collecting data using Spradleys' (1980) descriptive, selective and focused phases of fieldwork. Data was analysed using what Miles and Huberman (1994) refer to as a set of 'choreographed / custom built' techniques. Because ethnography is a term marked by diverse application, this study is conceptualised as a 'single community' (Spradley, 1980, p.30), 'topic-oriented' (Hymes 1978) ethnography.

Fieldwork revealed an apparent 'staffing illusion' on the General hospital wards, RN's were found to be under tremendous pressure to manage 'patient throughput', and an ever increasing case mix of 'dependent patients', within existing, or what became apparent, a diminishing Senior / experienced RN labour force due to a 'cycle of staff change'. Non-clinical managers placed a freeze on recruitment, followed by backfilling Senior RN posts with Junior RNs and Health Care Assistants (HCA). For Senior RNs this backdrop meant additional support and supervision demands on their role. To get through the workload many RNs held 'dual roles' to enable maintenance of safe patient care. The most significant finding explored in this paper is the RNs constant reference to 'Nursing is going backwards'. From the empirical data this was found to relate to the nursing labour process, which had moved from the gold standard 'Primary Nursing' system to Team Nursing (silver service) and increasingly evident were shifts where patient care could only be achieved through 'task allocation', referred to by the RNs as the bronze nursing service.

Introduction.

This is a study of the Registered Nurse (RN) labour process in National Health Service (NHS) Acute Trust general wards¹⁸⁴. The study was conducted when the NHS in England is in an unprecedented era of structural change, referred to as modernisation (Pollock 2004), emanating from New Labour NHS Plan (DOH 2000a). Modernization of the acute trust services were gaining momentum at the time of conducting this study as a result of a cascade of policies requiring NHS provider responses, policies emanating from the NHS Plan which are likened to jig saw pieces, released over time in reports containing clichés like:

- Liberating the talents
- Making a difference
- Hidden talents
- Role re-design
- Modernizing nursing careers
- Outreach
- Essence of care
- Working in new ways
- Improving working lives

This was therefore a moment in time when RN responses to NHS modernization¹⁸⁵ could be captured through empirical research. One construct which persistently evolved during analysis of the ethnographically derived data was 'nursing is going backwards', a construct endorsed by 'old' style prepared Senior / experienced RNs and 'new' style prepared fledgling Adult RNs. The findings now presented relate to changes in the ward nursing labour process, forced on Ward Managers by non – clinical managers through tactics ward based RNs felt they had no control over.

Ethnography as methodology in this study.

Ethnography was deemed the most appropriate methodological approach to explore and experience the 'day to day' RN role over a prolonged period before theorizing on factors affecting their role development and the ward based nursing labour process. The assumption underpinning the selection of ethnography was that 'any human group together for a period of time will develop a culture' (Patton, 1990, p.92), 'creates it's own reality or shared culture' (Holland, 1993, p.1461), hence creation and performance of a culture is not individual, but a shared social activity, providing individuals with a sense of social /cultural identity¹⁸⁶. Within a changing, modernizing NHS Edwards (2007) proposed ethnography as an empirical method particularly pertinent for studying 'the experience of work at the point of production' (p.19), because systematic observation can reveal important information on employees experiences of the labour market and the ways in which managerial controls are deployed.

Ethnographic fieldwork progressed through Spradleys (1980) descriptive, focused and selective phases. During the descriptive phase the ethnographic focus remained broad to ensure the breadth of RN practice was explored, the focused

¹⁸⁴ Not critical care / high dependency wards, and not day surgery wards, both of which also house Acute Trust surgical patients.

¹⁸⁵ Simultaneously the European Working Time Directive (EWTD) was triggering a sequential reduction in the number of hours worked by Junior Hospital Doctors', often referred to as the Improving Working Lives (IWL) agenda.

¹⁸⁶ Cultural identity is viewed here as comprising ideational and materialistic dimensions (Fetterman 1998).

phase comprised a more careful study of four grades of RNs¹⁸⁷. The final selective phase was spent validating the ethnographically derived themes and conducting ethnographic interviews. Data collection strategies described by Wolcott (1994) formed the framework for conducting fieldwork; experiencing [participant observation], enquiring [interviewing] and examining [studying documents]. Throughout fieldwork the researcher engaged in the everyday work of RNs, fieldwork covered the seven day week and the 24 hour day, the researchers philosophy of the 'style of being there' with RNs was as an RN, in a 'helper role', based on the feminist ethic 'reciprocity' (Lincoln 1985 p.280).

Data collection and analysis occurred simultaneously in this ethnographic study (Fetterman 1998, Hammersley and Atkinson 1998), from which the inductively derived construct 'sequential erosion' was unearthed in relation to the non-clinical management agenda of eroding senior 'old' style prepared RNs and their replacement with Junior 'new' style prepared Adult RNs or un-regulated Health Care Assistants (HCAs). The 'sequential erosion' construct was compared with referent constructs in the literature¹⁸⁸, a process Wolcott (1994) refers to as the final stage in ethnographic studies. This 'google' process led me to Braverman (1974) LMC, within which I discerned an understanding of his skill substitution thesis, which clearly made plausible the process of replacing the 'old' with the 'new' labour force¹⁸⁹. Evolving from LMC was an understanding that management can exert control over the labour process so subtle workers don't perceive its impact, because the memory fades, a management strategy Braverman indicated results in unanticipated and adverse consequences, which in the larger study were found in relation to surgical patient outcomes, but in this paper are reported as the effects on the conditions of production for RNs.

The Acute Trust where the study was conducted.

The Rodin is an acute trust hospital serving 400,000 residents in a once industrial city in middle England, one of the most densely populated places in the country, with residents experiencing high levels of unemployment and life expectancy in the lowest 15% (Census 2001). Death rates from heart disease and stroke remain significantly higher than the national average, and the rate of violent crime is reported to be rising. The hospital had in excess of 800 in patient beds, with executive projecting an increase in beds as a result of an ambitious expansion programme.

The organisational unit forming the ethnographic lens was a surgical directorate, a structure which came into being when Thatcher introduced the Acute Trust system (HMSO 1989), around the same time the Conservative government agreed to Project 2000 (P2K) where RN preparation was transferred into Higher Education (HE), replacing the General Nurse apprenticeship training with a 'generalist' HE curriculum. On implementing P2K there was a three year period in which nurse training systems were 'double running', old style apprenticeships were declining, as the new HE generalist Adult Nurses came into being. Government caveated the move into HE of initial nurse education, with the nursing profession having to accept a new grade of nursing assistant, the support worker. Government then made available money to replace the hospital student nurse labour force, money that was 'trickled into the system' enabling hospitals to replace student nurses in one of two ways. They could implement the governments 'new support worker', through introducing the NVQ framework

¹⁸⁷ The Ward Manager, Primary Nurse, Associate Nurse and Staff Nurse.

¹⁸⁸ Initially through a 'google' search.

¹⁸⁹ In this case the General trained SRN / RGN, with the generalist prepared Adult RN (and unregulated Health Care Assistants).

(NHSTA 1987, DHSS 1989), which opened the door for some hospitals to 'backfill' with what Braverman referred to as 'detail workers', the purchasing of dissociated elements, the semi or un-skilled Health Care Assistant (HCA). Alternatively the money could be spent on the 'gold' or 'silver' nursing labour process 'Primary or Team Nursing' respectively, through employing additional RN's.

When Rodin became an Acute Trust the directorate structure came into being, each directorate appointed a Head Nurse / Directorate Nurse manager (DNM). The newly appointed DNM for surgery was described by a Ward Manager as having **a monumental effect on the organisation of nursing and what us Surgical Nurses do (fieldnotes)*, with another Ward Manager commenting **she wouldn't believe what we have to put up with now, she wouldn't have allowed it to happen (fieldnotes)*. The DNM used the government money for replacing the student nurse labour force to implement Primary Nursing, through negotiating with executive a revised nursing establishment for the six acute wards. Each in patient ward comprised 28 beds, the revised nursing establishment led to four Primary Nursing Teams per ward, giving a ratio of seven acutely ill patients for each Primary Nursing team, who provide continuity of patient care on a 24 hour, seven days a week, implemented at a time when the government launched the Patients Charter 'Named Nurse' (DOH 1991), and the Strategy for Nursing (DOH 1989), both endorsed Primary Nursing on the grounds it led to high quality patient care. The Primary Nursing labour process was throughout fieldwork referred to by RNs as the 'gold' standard¹⁹⁰, on commencing the study it had been embedded on the wards for more than 15 years.

Alongside implementing Primary Nursing the DNM re-advertised all Senior Surgical Nurse posts, only appointing existing Senior Nurses into Primary and Associate Nurse posts if they agreed to undertake a nursing diploma or degree. Those appointed as Ward Managers were enrolled into the trust commissioned MBA or NVQ Level 4 management programmes.

The ethnographic findings.

This study emanated from concerns expressed by ward based RNs in relation to dissatisfaction with their conditions of production, particularly related to the nursing labour process 'going backwards'. Selective findings from the larger study are now reported in relation to the control tactics used by non-clinical management, Ward Managers and other RNs at the chalk face felt they had no control over. Initially the RNs views on the changes to the in-patient case mix are described, because acutely ill patients are the reason for the RN labour in the first place.

The patients: The reason for the RN labour.

The overwhelming view was that over recent years their wards are busier and house more dependent patients. A regular pursuit of Senior RNs has been to report to management the increasing throughput of patients and their increased dependency, messages which **fell on deaf ears (DNM fieldnotes)* because the constant managerial reply was **show me the evidence (fieldnotes)*. This managerial stonewalling led RNs to repeatedly tell me **we can't prove it, *but it*

¹⁹⁰ The word Primary refers to a person of 'chief importance'. A pertinent term because the Primary Nurse is the custodian of 'the quality of surgical patient care', the role model for quality care because they deliver direct patient care. They assess patient needs, plan care for others to follow [in their absence], deliver the care to meet individual patients needs, evaluate the outcomes and make appropriate changes. Additionally they pass on their expertise through their roles as mentor, preceptor, supervisor, teacher and assessor for a broad range of individuals through role modeling.

*takes four to turn a patient, *the case mix has changed, *but we can't prove increased dependency, *years ago we had monitor¹⁹¹ (fieldnotes).*

A Primary Nurse went so far as to estimate patient dependency had trebled:

Iv'e been here seven years and the dependency on the ward has trebled ... on my very first day on the ward as a student nurse, the beginning of my 3rd year I was in the yellow team and I'd got a lady in the first bed with a mastectomy, then a lady having an oesophagectomy, then a lady who had a hernia repair so those three had all come back from theatre, on the other side I had someone who had a hernia repair three days ago, somebody who'd had a mastectomy five days ago and then somebody who had an operation on her foot five days ago... these three were completely self caring, I'd got three totally dependent patients and three completely independent, so you can manage a patient caseload when it was like that now all my patients are fully dependent, it's gone up massively, dependency trebled in my view (Interview: Primary Nurse Denise).

Issues related to patient dependency were pursued with a Primary Nurse with over 10 years experience in the directorate

dependency is greater without question ... when I started there used to be three, four big cases maximum a week, majors¹⁹², whereas now there's at least eight, and then there seems to be, I mean I don't have specific evidence but there seems to be more people coming in as an emergency as well, not just old people but stabbings and shootings (Interview :Primary Nurse Grace).

The stark reality being, despite RNs having been continuously employed within this ever changing directorate they feel unable to prove to managers patient dependency and patient throughput have increased. Senior RNs recalled when they implemented Primary Nursing they used dependency monitoring systems to substantiate claims to good quality care, today they are no longer permitted to use these quantifiable methods as the Modern Matron explained ...

**I have no opportunity to compare dependency, yet in my experience of the changes over the years, the inception of the short stay unit has changed the bed occupancy on the wards, but all management perceive is the availability of two or more theatre slots, but we have increased the number of surgeons, therefore the workload that follows them in major cases is greater and so the nurses role with dependent patients is more, it's all about throughput (fieldwork discussion with the Modern Matron).*

Management Messages to chalk face RNs.

The managers in this clinical division are colloquially referred to by clinical RNs as 'the non clinical management', a title which I came to understand had evolved over recent years from a conflict between their, and the clinical RNs agenda, as a Primary Nurse illustrates

¹⁹¹ MONITOR: A patient dependency system used in the late 80's and throughout the 90's.

¹⁹² [what are majors ?] ... bowel resection, stoma formation, an AP (abdo perineal resection of rectum)...

I don't know what their agenda is, I don't think they give support at ward level at all, the only time you see them is when they're asking for beds, if there's a bed crisis and they want to move people right now, patients who physically and surgically aren't ready to be moved, and it doesn't matter whether they've got a consultant decision, all they want is an empty bed at the end of the day ... (Interview: Primary Nurse Faith).

After a day spent with a Ward Manager I enquired about the content of the letters and emails I'd seen her spend a lot of time dealing with ...

They're ward directives from managers and it's duplication, they go to all the Nurse Managers ... and they all seem to want to pass the work all down to you and YOU MUST DO IT, there's no choice, no consultation, very seldom consultation ... I get it in duplicate, I honestly do not know, hands on heart, I don't know what their job description is, I don't know what they're supposed to be doing, if the girls are asked they don't know who they are, the only time we see them is if it's in a bed management capacity (Interview: Ward Manager Lucy).

Powerful messages come to shop floor RNs from the Trust Board via non clinical managers¹⁹³, messages which fall into two categories; the money, money, money messages, and the policy, policy, policy messages. The money messages relate to a constant drive for cost containment, and where possible cost reduction within the directorate. Each Ward Manager has budgetary responsibilities, mooted in the trust as $\frac{3}{4}$ of a million pounds, although the Ward Managers overwhelming views were, they have no control over these so called budgetary responsibilities.

For Ward Managers ensuring their wards are safely staffed is a priority, but the message from management is that costs in the trust need to be cut, and staffing is the area where this can be achieved, as a Ward Manager explains

Being cost conscious is the fact every month you get spreadsheets back, I'm looking, comparing last months budget to what I've spent this month with the money they give you annually ... but we don't have anything to do with the money we're actually given, ... it's all at the business plan side ... I only know from the spreadsheets.

You could break it down because on the spreadsheets I get non-pay and pay, and out of that you've got all your various grades, costings per annum, with the on costs obviously... but the frustration is I'm never in at the beginning to say where and how much we've got to spend and I have to move money around. I'm cost conscious but have no control ... if I save money, it's not ploughed back, because its all lumped together as non pay (Interview: Ward Manager Lucy).

On all wards a Senior Nurse has an additional role of 'managing the ordering of ward stores', in which they are acutely aware this has to be done within an ethos of cost containment. A Primary Nurse 'stores manager' when asked about being cost conscious responded assertively

¹⁹³ The two monthly forums where management messages are disseminated to Ward Managers are the Divisional and the Directorate meetings, in addition messages come to RNs attached to pay slips, via the telephone, in letters and memorandum, in the trust magazine, via planned and impromptu ward visits and email.

I am cost conscious, i'm a wise spender on products and that sort of thing, I don't order luxury items like we used to, talcum powder and toiletries I don't order any of those sort of luxury items like we used to do ... (Interview: Primary Nurse Beth).

Whilst RNs feel they are wise spenders, this is not enough, management want more, their philosophy is cost reduction through paying for ward developments with money generated by staff, and donated by 'grateful patients'

We've just done a sponsored walk, we've raised £500, now we phoned the [Finance Director] to see if we can put it into an account purely for us and we can't do it, not like we always used to have [he tells us] there's too many fraudulent cases going on, so they stopped it ... (Interview: Ward Manager Beth).

A recent edict from management resulted in the centralizing of 'grateful patient' donations into a 'surgical unit fund', the difficulties this creates are backstage as a fieldwork experience illustrates ...

**regarding the essence of care where ward staff and patients identified the need for a place where 'bad news' could be given, to achieve this we've done the sponsored walk, and a patients relative has offered to do the painting up of the old store room and we were going to purchase a two seater sofa and some pictures from IKEA, now it's all on hold, we've raised £500 but we can't spend it on what we need ... (fieldnotes).*

The policy messages are all about responding to government targets aimed at reducing waiting lists and avoiding the breeching of the four hour waiting time in A&E, deemed by ward staff as **an absolute management priority (fieldnotes)*. Numerous other government policies were cascaded down to RNs for comment or implementation during fieldwork, but the Essence of care (DOH 2002) was for Senior and Junior RN's the last straw, as a new RN explained ...

... it's patronising this essence of care, it's what we're doing anyway, the care is already good, yes it is good, its like out of the textbook, it's very good [have you worked at any other hospitals ?] I've done agency shifts, and this unit has better care than a lot of other areas I've worked on, particularly due to Primary Nursing (Interview: New RN Pamela).

Regarding 'doing the work' to implement Essence of Care, RNs were reticent this was not a proiority ...

**because care is so good here, management didn't bother us on this policy, until government wanted data on it (fieldwork with Modern Matron)*

**we implemented it eventually and proved care here was good, the best, we did a few changes like the bad news room, but we knew we needed this before the essence of care (Interview Ward Manager Beth).*

Simultaneously with the overt drive for cost containment and cost reduction by non-clinical managers, clinically based RNs received covert messages the cost

containment and cost reduction principles did not apply to the non clinical workforce. Messages which came in the form of employing increasing numbers of non-clinical staff, including a circa £30,000 fraud officer, contracting with consultancy firms, creation of numerous audit clerk and clerical positions and finally the pervading of the trust with Service Improvement Teams¹⁹⁴ (SIT's). Each new administrative, clerical and management recruit, to function effectively was provided with a computer, office space, access to a telephone and other work related tools of the trade. During fieldwork the rising number of non-clinical managers and their support entourage relocated into a state of the art refurbished building, taking with them the only photocopier and secretarial support available within the vicinity of the surgical services, both of which were called on constantly by clinical, front line surgical staff.

The ward staffing illusion.

Enter any General Ward on a weekday and you may well be as surprised as I was at the number of staff on duty, surprised because this is in sharp contrast to media headlines (and RCN press releases) which express concerns regarding the shortage of nurses in the NHS. After several weeks of finding my bearings ward staffing was found to be an 'illusion', because the once exclusive and distinctive uniform donned by RNs¹⁹⁵ have been recycled and are now worn by ancillary, medical records, and contract cleaning staff. A recycling phenomena which creates an illusion of a well, if not over staffed hospital ward. Although numerous uniformed staff are present on the wards the question turns to who are they?. On closer examination many are not part of the nursing establishment¹⁹⁶, but are part of a transient workforce made up of Agency staff, Student Nurses', Return to Practice and Adaptation Nurses.

Primary Nursing: A fragile labour process.

The number of Primary / experienced RNs was found to be declining, because when one tenders their resignation, management put a freeze on this labour force vacancy. To maintain Primary Nursing the only option available to the Ward Manager is to put an Associate Nurse into an 'acting up' role, which leads the Associate Nurse to an acute awareness of their additional responsibilities

being the acting Primary Nurse, you feel responsible 24 hours, not a worrying responsibility, but you know your responsible. I've left messages knowing that I won't be back till Friday for my staff so they can take over where I left off, because I know things won't have been done, and I'm aware of that, I'm aware I'm accountable (Interview: Acting Primary Nurse Eloise).

The Primary Nurse role is pivotal to the quality of patient care, but because the numbers of Senior RNs on each ward is dwindling, those remaining find themselves increasingly being **pulled further from their patients (fieldnotes)*, a worrying situation for Seniors because the wards are increasingly staffed with Junior RNs, experienced RNs know have undergone a training less acutely focused than theirs, resulting in seniors increasingly finding themselves in a situation when they are in charge of the ward, constantly check up on juniors

¹⁹⁴ Service Improvement teams (SIT's): Teams employed under the NHS modernization agency as change agents, under the umbrella 'Service Improvement'.

¹⁹⁵ The medium and dark blue uniforms traditionally associated with staff nurse and sister and the white uniform of the student nurse.

¹⁹⁶ Nursing Establishment: a term used within health care to indicate the agreed permanently employed nursing staff.

I recently found a junior trying to administer blood to the wrong patient, they hadn't checked the blood with anybody else and they were going to put it through a normal giving set ... I've noticed problems, silly things, but things that matter to patients like mouth care, patients who've got oesophageal cancer who can't even swallow their own sputum, care that's not given ... standards do vary, standards vary between each nurse, I think that's one of the roles I've got, it's my job to make sure it doesn't vary ... that every single patient gets the care ... they've had their bowels open or not, mouth care has been done and that's the difficult part ... because it tends to get me angry... I think basically that we've got to achieve a high standard with the minimal amount of resources, and that we've got to be happy, with our lot, that's what the [Chief Executive] wants us to be, the happiest hospital in the world, it's more for less and he just wants us to be happy, but they don't want to make us happy by listening to us ... at the end of the day the managers aren't nurses and that's the main thing ... even the one who was a nurse I think they have forgotten what it's actually like to come on a ward and wash someone ... (Interview: Primary Nurse Denise).

The Associate Nurse is the deputy to the Primary Nurse, the 'inbetweenie' RN labour force¹⁹⁷, this grade is also being dwindled down through the freeze on vacancies, then converting the position to a junior grade. The Associate Nurse position is unappealing to capable junior RNs because there is little remuneration for the extra hassle when they can earn the same doing an extra agency shift, a Ward Manager explains

trying to get an Associate Nurse is an absolute nightmare ... [the juniors] don't want the extra responsibility, there's no incentive, their salary is good, I mean they go from a bursary to a salary with enhancements for night duty and weekends, they're quite happy with their lot ... there's not a lot of financial incentive to step up to an Associate Nurse ... (Interview: Ward Manager Lucy).

This trust spent their P2K replacement monies on additional RNs allowing them to implement Primary Nursing, subsequently there are only one or two Nursing Auxiliaries on each ward, who have had no formal training. One Auxiliary Nurse during fieldwork explained **i've just received my 25 years long service award (fieldnotes)*. This labour force are 'floaters' in the Primary Nursing system, when on duty they are allocated to the heaviest bay to assist the RN, and are an always busy labour force, when not feeding and washing patients their time is spent housekeeping and generally their presence within the vicinity of patients is continuous for their shift.

A new labour force Ward Managers were requested to introduce into the ward team is the 'Ward Assistant'. The first they heard of this was via a letter informing them **this had been agreed at a Divisional Manager Away Day (fieldwork document)*, attached to which was a job description summarizing the new grades duties, indicating **the appointee would be accountable to the Ward Manager but professionally accountable to the head of Hotel Services (fieldwork document)*.¹⁹⁸.

¹⁹⁷ thus called because they are sandwiched between the Junior and the most clinically capable Primary Nurses.

¹⁹⁸ Each ward also has a part time Receptionist, a key player in the smooth running of the Ward, their role is both front and back stage, operating from her base, the Nursing Station within arms reach of three telephones, the patients notes trolley, two computers and the mountains of patient related paperwork that needs filing. Their duties range from welcoming new admissions, showing them to

But there are moves in the trust to develop NVQ prepared assistants to support RNs, the NVQ project leader presented an overview of this at a Ward Manager meeting, requesting one RN from each ward be sent for NVQ assessor training.

In the Directorate, after what the Senior RN's tell me has been more than a decade of RN staffing stability they are now faced with a constant 'cycle of staffing changes' as a result of Senior and Junior RNs leaving due to dissatisfaction with their working conditions, and the backfilling agenda invoked by management, presenting each Ward Manager with the issue of maintain safe staffing for their vulnerable surgical patients.

Maintaining safe staffing: Ward Manager tactics.

The major headache for the Ward Manager is the struggle to maintain what they deem are 'safe' levels of staffing, because they feel the nursing establishment is **at rock bottom (fieldnotes)* even before they have to manage staff sickness, maternity leave and an ever increasing demand from Junior Doctors to do the bloods and other tasks once in their domain¹⁹⁹.

In an effort to maintain ward staffing and to ensure the ward fulfils the managerial policy developments, Ward Managers devised creative solutions to ensure; recruitment and retention of new RN's, the reduction in nursing overlap through changing shift patterns, and allocation of extra responsibilities to Senior RNs. Creative solutions implemented alongside the trusts recruitment of overseas nurses, and the continued use of agency staff from an unpopular nursing agency.

Growing your own.

Within the directorate there is a **growing your own (fieldnotes)* philosophy, aimed at ensuring the Student Nurse has a good experience during placement, **it's about being good to the student nurses ... about making them want to come back (Fieldnotes Eloise on a night shift)*. As Amanda explains

You tend to identify whose gonna be a good nurse, the student nurse who wants a job and which ones don't, and they'll say to you are there any jobs coming up when they're coming up to be qualified and you sort of know who's gonna apply for jobs ... (Interview: Junior RN Amanda promoted to Associate Nurse during fieldwork).

Student Nurse placements are important to RNs because through providing a good student nurse experience this aids future recruitment, a philosophy Pamela experienced which led her to want to come back to surgery:

in my training the majority placements were surgery, it was the luck of the draw, this ward was my first placement, then I came in the middle into the second year, then I chose it as my rostered service, so it was quite natural for me to want to come here, I liked it and felt supported (Interview: New RN Pamela).

their bed and checking the accuracy of the patients biographical data, to fielding all phone calls to the ward, making appointments, booking transport, liaising with other departments on ward maintenance requests, and supporting Junior Doctors who are floundering in their new roles regarding the systems they are expected to master on the new and unfamiliar wards. The duties of the Ward Receptionist are non nursing duties and the importance of their role, and the amount of work they do only comes to light when they are on annual leave, or off sick, because there is no backfill into the role, RN's fill the gap.

¹⁹⁹ as a result of the EWTD changes to duty rotas and the introduction of Protected Sleep Time.

Once Junior RNs are recruited the Seniors major concern relates to the Adult RN curriculum, because acute care content in the current RN curriculum is minimal, with the number of acute trust placements during the three years now negligible, leading to the general feeling new RNs on qualifying can't pass a naso-gastric tube or do the drugs, skills previously seen to be routine on registration.

The cultural practice of 'passing on nursing expertise' from Senior to Junior RN relates specifically to patient care standards Seniors expect, and essential for safe surgical patient care, standards which emanate from the nursing 'era' the seniors trained in, they feel has been eroded in student training today, leading the new RN to be vulnerable when choosing to enter a career in the Acute Trust. Diminishing anatomy, physiology, disease based knowledge, surgical skills and surgical ward placements in the Adult nurse curriculum are seen as the fundamental reason why the tools of the trade for safe practice in surgical wards are not present in newly employed RN's. Lucy a Ward Manager explains her concerns regarding the present curriculum

as a surgical nurse I can't understand how they [the juniors] can nurse someone whose had an appendicectomy, if they don't know where the appendix is, how do they know where it's gonna hurt, how can they possibly nurse someone when they don't know which bit they've taken away (Interview: Ward Manager Lucy).

Although as one Primary Nurse pointed out, you can't blame the situation wholly on Project 2000, as she undertook the first P2K course, her concern being how the curriculum has recently changed, leading juniors to experience problems on Registration

... during our training we had longer periods in the hospital, we had a taster of surgery in our first year and then we went back to surgery at the end of our last year, by then we had developed our knowledge and skills for our assessment ... managing a whole bay for a whole shift, on reflection to what occurs now that was an easy assessment because we were often left in a bay on our own, on a shift anyway and we got on with it ... (Interview: Primary Nurse Beth).

The need for a more formal approach to support newly appointed RNs has evolved as a direct result of **a lesson learnt (fieldnotes)* from high attrition from the previous cohort of recruits [8 out of 10 resigned during their first 6 months of employment], which Seniors put down to **too much, too soon (Interview: Associate Nurse Amanda)*, what Beth described as the 'culture shock' from a student to an RN ...

... I think now it's a hell of a culture shock for them from being a student one day and then having to do it for themselves, they get burnout and get upset, you try to protect them and that is why you double check, because you spot something they haven't done, you go and say look this is something they've missed, try and teach them so they won't do it again, instead of the problem becoming a big issue, before you know it you've got a critical incident on your hands ... averting complaints, averting risk (Interview: Primary Nurse Beth).

To avoid the 'wasted time' of recruiting and training up new RNs, only for them to leave, the Seniors put in an 18 month programme / retention strategy, comprising an induction week, a surgical competency development package and a dedicated Primary Nurse role to support the programme, aimed at ensuring new

RNs develop skills to practice as a capable RN. Thus the fledglings are enrolled onto an 18 month in house rotational programme, **to make up for the shortfalls in their HE preparation (Fieldwork discussion)*, the benefits being they will be retained and ready to apply for an Associate Nurse post on completing the programme.

After the Seniors finalized the retention strategy, the key to its implementation was creation of a post for one Primary Nurse for three days a week, the Clinical Skills Facilitator (CSF). The Modern Matron approached management for the role to be made official, which was fraught with opposition from the Divisional Nurse Manager, whose response was **it's un-necessary (fieldnotes)*. Against this backdrop of opposition Ward Managers decide to go it alone, freeing up the Primary Nurse for one week to prepare the paperwork, one week to deliver the new recruits induction and then making the CSF post a two day a week secondment from a full time Primary Nurse post. Although an exciting development for the directorate, from the perspective of the Ward Manager releasing the Primary Nurse this left her 'carrying a ghost'...

she's got a dual role at this moment in time she's got 60/40, a dual role as clinical nurse and teaching, the CSF role it's been excellent, done on the back of retention issues, the Juniors she's nurtured are happy, they're content, they feel fulfilled and they're now confident now I'm not saying that this didn't happen before but the fact was it was very ad-hoc, hit and miss, they didn't have someone they could actually say – well I've got a problem ... with this particular group we've been lucky, on the back of that role [the CSF] has made a massive impact I had to make a sacrifice in losing her for 2 days a week but the benefits are there ... I pay for the role ... it is being generous ... it's a ghost post (Interview: Ward Manager Lucy).

The Dual Role RN.

As seen from implementing the CSF role, this was created from an existing Primary Nurse post, an approach to getting through the work and meeting service and management demands is to allocate to experienced RNs additional duties. The CSF tells me a lot more about the new role which she would like to be made permanent ... but discloses why this won't happen ...

You're contracted to anywhere in the directorate ... so management can do anything with you ... I see a big future for this role but I've been told its not funded, they are not looking at it laterally, they're not looking at it how much money they're gonna lose when they lose so many staff nurses because they don't feel supported ... and if you lose staff, invariably you're going to have to employ agency staff for the interim ... they're not looking at the long term future at all. Whilst I'm doing this 2 day role I'm still practising on the ward, doing 3 days a week ... there's a lot of those roles around the directorate its getting us on the cheap, to be honest ... (Interview: Primary Nurse Denise).

A further case in point was the trust requirement to introduce the Essence of Care, each ward had to nominate a Senior RN to drive this through the ward and report to management what they had done. A Primary Nurse currently in a dual role as a Clinical Nurse Specialist (CNS) told me the role evolved because workload in the service had risen tremendously, but the role she tells me leaves the ward short staffed.

To get through the work demands RNs are allocated additional role dimensions, extracts from fieldnotes indicate this is a common approach to respond to managements demands within the existing labour force budget;

**Kate an Associate Nurse is allocated two mornings per week to enter data into a computer on risk reports in the surgical directorate.*

**Mary a Primary Nurse spends two days of her working week as a specialist GI Nurse due to the need for the service to accept rapid referrals from GP's. She tells me last year 159 patients were referred to the nursing service and in just the first four months of this year we have received 100 patient referrals, we had to pull the team together ready for the cancer review.*

**Alice a Ward Manager is placed for two weeks in an Acting up position whilst the Directorate Nurse Manger is off sick, and as a knock on effect Jane a Primary Nurse has to act up for the Ward Manager for the next two weeks.*

**Three urology ward staff nurses have Hospital to Home roles, taking them away from the ward for anything between half a day and three days a week (fieldnotes).*

These bolt on role for Senior RNs was the Divisional Management Teams preferred model for addressing government and trust initiatives, including implementation of the trust risk management strategy and collecting and processing audit data on surgical targets. Management initiatives achieved with no increase in staffing. Senior RN's are therefore likened to sponges, soaking up government and management agendas, as opposed to delivering direct patient care.

Filling the gaps: The use of agency personnel.

There is a heavy reliance on the use of agency staff on the wards as a result of the freeze on employing permanent staff. On one ward they have an agency nurse on nearly every shift, which creates problems for the permanent staff because of **the variable quality of staff from the agency (fieldwork discussion with a Primary Nurse)*, many are employed at an assistant grade, and are current student nurses, and a cause for concern for some Seniors ...

students used to only be allowed to do agency work in their third year of training, but as a Primary Nurse pointed out it appears you can be on the agency now after signing up to [nurse] training (fieldnotes).

The trust contracts with two privately run nursing agencies, when the contract for one came up for renewal Ward Managers expressed concern as to the quality and reliability of the agency and were very unhappy when the trust renewed their contract, without consultation at operational level. The agency nurse situation came to a head at a divisional meeting, where one Ward Manager had placed the issue on the agenda, it came to her turn in the meeting and she told the chair the 'James' agency were still sending unsuitable staff which was noted but not discussed. The problems some agency staff bring to the ward for the nurse in charge are numerous ...

I've had a lot of agency, and I ask for regulars and you get somebody you don't know from before, it is difficult if you don't know them ... it is difficult being an agency nurse working round different places ...

sometimes it's been better just to do it yourself ... sometimes it's just better not to have anybody, given what they've sent you (Interview: Ward Manager Molly).

An RN explained her concern about the fact nobody is sent on a regular basis, even when the person at the end of the phone knows you, one incident I was party to explores this

**an agency nurse on a block booking for three night shifts was here last week, she hadn't done much all night [on her second shift] then her mobile phone went off so she went to the locker room, answered the call and then just left the ward ... it was six in the morning, she wasn't due to finish till 7.30 and we were really busy (fieldnotes)..*

Amanda revealed the true extent of problems regular RNs face when employing agency staff, when she indicated it is sometimes better to do it yourself

a lot of agency nurses won't do things ... what I mean, you'll get an agency nurse that wouldn't take a drain out, you'd expect them to do it, but sometimes when you get one employed at a junior grade they won't do the drugs... I respect them when they say I won't do IV's, that's fair enough, they haven't been trained in this trust, although we haven't got any protocols saying you need to do our course here ... if I went to another hospital I wouldn't do IV's, but they won't do oral drugs (Interview: Associate Nurse Amanda).

Occasionally there were positive comments about agency staff as Degas Ward Manager indicated **you can build a rapport and they'll return (fieldnotes)*. Although the overall opinion seems to be management want ward staff to cut agency costs, but Senior RN's need them to fill the manpower gaps

... the cost of agency staff as far as i'm concerned isn't an issue, the wards got to be covered at the end of the day ... I've had times when I haven't been able to get hold of management anyway ... and there's a crisis in staffing and by the time they get back to me its too late, i've had to stop on the whole day ... it's safety, it's your professional judgement (Interview: Primary Nurse Beth).

More support and more supervision demands.

Recruiting overseas nurses was sold to RNs as the trusts approach to fill supposed vacancies, a decision made by management without consultation with Ward Managers. Overseas recruits in their own country are RNs but once in the UK are required to undertake an adaptation programme prior to being entering onto the NMC Register. This situation resulted in the trust having to develop a hospital wide competence programme, co-ordinated by a lead nurse, with each recruit being allocated to a Primary or Associate Nurse. The journey to registration for the overseas nurse requires teaching and assessing by the Senior RN for between six and nine months, until the recruit can demonstrate the same level of skill in the statutory competencies for NMC registration as home trained RNs.

Senior RNs completed their support of the first cohort of Adaptation Nurses but then raised concerns there were no ward vacancies, telling management home trained RNs were asking about jobs, concerns which fell on deaf ears because the second cohort

were en route. A Ward Manager discussed current recruitment, and expressed her concerns ...

I've got two [overseas nurses] which I've taken on, but I do feel we were hoodwinked into taking them, we had junior grade vacancies but I'd actually got a list of 2 or 3 students that want to come back, they were students here... they're [the overseas recruits] on our budget now ... it wasn't made clear these girls were going to take up my vacancies ... they just have to slot into vacancies ... as far as I'm concerned it could be an issue with equal opportunities, in the fact they haven't gone through interview, they haven't been short listed, they haven't gone through any of the rigmarole the juniors, the new girls go through and yet they're just given a job on completing six months (Interview: Ward Manager Lucy).

A further Ward Manager explained she'd been informed overseas recruits were free regarding her nursing establishment budget throughout their period of adaptation but on receiving the monthly spreadsheet found them employed into RN vacancies at an auxiliary grade, she questioned this with a manager following which **I was called to the office to discuss it (interview)*, the outcome of which she declined to disclose.

Promotion: Forget it.

After a period of being an Associate Nurse, during which many have acting up experience, the next step is promotion to a Primary Nurse, but opportunities here are limited due to the freeze on senior posts. After implementing Agenda for Change (AfC) the Primary Nurse paid at a band F were re-graded Junior Sister and re-graded Band 6, which came with a small increase in pay. The floodgates then opened in the trust regarding a skill mix review, and re-configuration of the surgical wards. The outcome of which was the issuing by senior management of new 'agreed' staffing levels, and ward closures demonstrating a dramatic decline in the number of band six RN posts shown in Table 1²⁰⁰.

Table 1: Ward Nursing establishment changes at Primary Nurse / AfC Band 6 (fieldwork documents).

| Ward | Primary Nurse (Band F) beginning of fieldwork. | Junior Sister (Band 6) following skill mix review and ward reconfiguration. |
|----------------|---|---|
| <i>Renoir</i> | 4.72 | 2.00 |
| <i>Sheila</i> | 6.00 | 2.00 |
| <i>Degas</i> | 3.80 | Ward due for closure |
| <i>Monet</i> | 5.80 | 2.00 |
| <i>Klimt</i> | 4.80 | 4.30 |
| <i>Cezanne</i> | 1.00 | Ward due for closure |

²⁰⁰ For the Primary Nurse, role development and promotion, in the ideal world would be in one of two directions; Ward Manager or Specialist Nurse, but after implementing AfC, and the skill mix review management took drastic measures: a freeze on all nursing vacancies across the trust, the introduction of a process of reapplying for posts under the skill mix review, a downgrading of some Primary Nurses (band 6) to band 5 posts and displacement of Associate and Primary Nurses into other areas of the trust. The ultimate clinical role in the directorate structure is Modern Matron, but few opportunities are available for acquiring one, because managements philosophy is 'secondment' into or 'acting up' from the pool of existing Ward Managers and Specialist Nurses'.

Following formal withdrawal from the fieldwork site in my academic role²⁰¹, alongside a somewhat obsessive daily survey of local evening and free newspapers has meant I have been able to continue data collection regarding changes in the Acute Trust and the RN role. This additional, post fieldwork data was recorded in a daily journal comprising fieldnotes, memorandum and newspaper cuttings, a data collection strategy Mandelstram (2007) employed in the preparation of his recent text on NHS change. The post fieldwork journals were subjected to a final analysis which revealed shop floor Acute Trust RNs have been subjected to further modernization / scientific management developments;

- A revising of RN job descriptions.
- Trustwide Nursing skill mix review.
- RN's under AfC banding who received a band 6 or band 7 were required to re-apply for their jobs.
- Unsuccessful applicants placed on the bank and required to work 'anywhere needed'.
- Downgrading of many RN band 6 and band 7 posts.
- Voluntary and compulsory RN redundancies.
- Re-organization of Modern Matron posts: 12 positions reduced to 8.
- Degas, the 28 bed surgical assessment ward closed, emergency surgical admissions now admitted to a 48 bed assessment unit.
- Specialist RN's [CNS and ANP] required to participate in time and motion studies through filling out of an hour by hour electronic diary.
- Increased NVQ training

Going Backwards: Pulled away from the ward and away from the patients.

From Monday to Friday, during the hours of daylight, and providing the Ward Manager is not on annual, sick, maternity or study leave each ward is headed up by a Ward Manager, although even when on duty they are regularly pulled away from the ward to attend meetings. Because the wards are open twenty four hours a day, seven days a week, a week comprises 168 hours and a full time ward sister post is 37 ½ hours so for 130 ½ hours someone other than the Ward Manager is in charge, a role referred to as the Ward Co-ordinator.

Staffing the wards in the Primary Nursing labour process requires a minimum of four RNs, one for each of the four teams, giving a ratio of one RN for seven surgical patients. So on a weekday if the Ward Manager is co-ordinator ** we need a minimum of four permanent staff to provide safe care for the surgical patients and me running the ward (fieldnotes – discussion with a Ward Manager)*. More and more often the ward is staffed with four RNs, so the most Senior Nurse on duty has to head up a Primary Nurse team at the same time as being the ward co-ordinator. Primary and Associate Nurses' describe this as occurring more frequent, and a situation causing them to be constantly called away from their role as Primary Carer for seven patients, because another Primary Nurse team is headed up by an inexperienced new RN or an auxilliary from the agency who **often has a big case in their bay²⁰² (fieldnotes)*.

For the most Senior RN on duty the knock on effect is they are constantly called away from their seven patients and as one Primary Nurse co-ordinator indicated **no one does my patients care why I am doing theirs*

²⁰¹ as a Senior Lecturer in the School of Health has enabled maintenance of links with some RNs still in employment within the surgical directorate, and others who during and following fieldwork displaced into Primary Care, now re-training to become Advanced Practitioners.

²⁰² 'A big case' is a colloquial term used to mean a patient who needs a lot of technical care or is in a situation where they require almost constant attendance by an RN.

Today i'm on a late shift and in charge ... and I have a bay [of surgical patients]. I have an [overseas] adaptation nurse in a bay, a junior RN in another, and I have an agency Nurse ... so I am running my bay and there's no problem with my patients but the other bays I have to be checking up on them, pop in and check they're alright and again you've probably got a ward round or two to do, on the ward round they stand with you but they probably won't say a lot they're scarred, so I have to know the whole ward, all the patients (Interview: Primary Nurse Tina).

Being the co-ordinator of a shift is a big responsibility, all about having to know every patient on the ward²⁰³, so they can act quickly if a doctor arrives on the ward, or there's an emergency to deal with. The RNs role expands when they are ward co-ordinator because they have to support 'others' caring for the patients, and in some cases they have to 'do the care' if the member of staff is unskilled in a particular task, or it's beyond their jurisdiction, which is frequently the case because the co-ordinator can often find themselves giving the IV drugs to every patient on the ward, alongside checking up on poorlies, and coping with a crisis.

The theme 'nursing is going backwards' was mooted around at the beginning of fieldwork, when a Ward Manager at the first Sisters Meeting I attended commented **nothing's new, nursings going backwards it's the enrolled nurse by another name (fieldnotes from a meeting where the discussion was introduction of level 3 NVQ support workers)*. With the passage of time I came to an understanding which aspects of nursing the RNs believed to be 'reverting back' to previous ways of working, ways of working they felt they had left behind as a result of introducing Primary Nursing.

The most significant aspect of nursing viewed as going backwards is the labour process Primary Nursing, created in the directorate in the 90's, now increasingly difficult to sustain. A Primary Nurse explained that because management have not replaced her Primary Nurse colleague, loss of this one experienced RN made a significant impact on the ward ...

Because [Jane] has not been replaced, me and another Primary Nurse have had to split the ward in half, we had to go back to Team Nursing and it doesn't work, there's too much to do, too many patients (Interview: Primary Nurse Hannah).

A Ward Manager agreed with this observation **I tell you just going back to team nursing for a month was a nightmare, hopelessly a nightmare (Interview: Ward Manager Lucy)*. Throughout the Senior Nurse community moving away from Primary Nursing is constantly criticized

some wards because of the staffing levels decided they had to do away with Primary Nursing, now that's all very well, but task allocation is about the hardest to do, you actually use more leg work, you use more time team is a little bit better, but I found you're looking after a bigger group of patients, you are doing more running backwards and forwards particularly with theatre you might have the one nurse that goes for every patient. With Primary Nursing one person goes for their patients. You know, I would make sure I'd got

²⁰³ **their diagnosis, their past medical history, what operation they've had, how they were on return to the ward, what's improved or what has deteriorated (fieldnotes)*.

the staff, even book agency staff to continue primary nursing ... but they're stopping us ... (Interview: Ward Manager Kathleen).

Although as Beth explained, going backwards is inevitable, given the current trust climate to cut nursing costs because we have to maintain safety

the only way that you can get through the workload is to adopt task allocation, by doing task allocation you know that when you are very short staffed, to me, it's the most feasible way of getting patient care done safely, and you know every patient has been attended to for the minimum sort of care for what that level of clinical skills that member of staff has got (Interview: Ward Manager Beth).

During a Ward Manager meeting the Modern Matron expressed concern it wasn't just Primary Nursing going backwards, but also the systems for nurse development, an example given was that there had been no nursing audit for years

**we used to do it annually and monthly, organisational and local, in the directorate, and in the wards, the wards also had their own, we used to develop nursing based on the audit, but it's just been stopped, managers say we don't need it we do, but what can I do about it ? (fieldnotes from discussion with a Ward Manager).*

Interpretation of the findings.

At the start of fieldwork this Acute Trust had a strategic plan promoting aims for excellence and expansion in clinical services, Senior Management predicting a growth in the labour force of five per cent over the coming five years, and a Strategy for Nursing indicating there would be recruitment of more Nurses and a reduction in the number of vacant nursing posts (at any one time). Strategic aims and a philosophy displayed and promoted throughout the trust.

These aims were somewhat tempered by middle (non clinical) managers, whose operational philosophy was **modernisation within a limited, if not reducing budget (fieldnotes)*, evidenced in the themes 'cost containment' and 'cost reduction', and reinforced to RNs through overt and covert authoritative tactics, for example turning up on the ward and questioning Ward Managers decisions regarding employing agency staff. Covertly middle management reduced the Senior Nurse labour force on a month by month basis, without consultation with the Modern Matron or the Ward Managers.

Control of the nursing labour costs in the directorate was achieved through a process of placing a freeze on Senior Nurse vacancies followed by their substitution with less costly Junior RNs or HCAs, resulting in slow erosion of the nursing skill mix. Because monthly nursing establishment spreadsheets were distributed to Ward Managers from the Divisional Manager office by snail mail, with a covering slip **requiring immediate checking and return of post (fieldwork documents)*, Ward Managers did not keep copies of these, because I was on the distribution list I did, which provided the evidence to support the assertion managers were in control of nursing labour costs through a process of 'sequential erosion'.

One explanation of the construct 'sequential erosion' evolved following investigation into the causes of the USA space shuttle disaster 'columbia'. A proposition emanating during the post-disaster investigation was that space programmers were found to be trying to '**do more and more with less**', as a

result of a 40% decline in the money allocated to the project, combined with a change in how that money was spent. The movie 'Challenger' (2006) made after the disaster acknowledged sequential erosion was a plausible reason for the disaster, with some project staff suggesting

we don't accept it, we get used to it, almost without knowing it we lower our standards each time, [so over time] till they become rock bottom (*Challenger*. 2006).

leading one analyst to suggest, 'budget cuts mean short cuts' (*Challenger*. 2006).

Due to the freeze on Senior RN vacancies Ward Managers brought into play compensatory mechanisms like 'acting up' roles to ensure wards had Senior RNs as co-ordinators, although it was made clear to applicants these were temporary positions, with no increase in pay or grade. A further tactic to ensure additional non-clinical workload requirements were met, was for Ward Managers to allocate to Senior RNs additional role dimension, making them into 'Dual Role' RNs, pulling them further away from their direct patient care role in the Primary Nursing labour process. Presently backfilling in the trust is with Generalist prepared, junior Adult RNs, although moves are underway for a new backfilling strategy following the appointment of an NVQ training co-ordinator. Senior RNs concerns extend beyond the nuances of the new NVQ system in Rodin, because their real and more fundamental concerns relate to the fact they feel they just can't cope with any more competency development programmes, or supervision requirements.

The construct 'with less' came to light in the analysis process, and is applied to there being less RN labour force time to deliver holistic care in the Primary Nursing system. RNs are finding themselves increasingly delivering task based care because of the Junior Doctor skill substitution agenda, an up-skilling agenda resulting in more technical care for RNs to deliver for their acutely ill patients, as a result of substituting tasks from one occupationally employed group of staff, compounded by the implementation of the Junior Doctors Modernising Medical Careers (MMC) strategy in the form of the new FY1 and FY2 status and the subject of a future paper.

Less holistic patient care time is also attributed to the RNs having to respond to the modernisation agenda through becoming a dual role RN, the add on role dimension inevitably removed them from direct patient care and their supervisory role with juniors and the transient workforce of agency and other personnel in their wards. This situation leads to a dilution of expertise on the general wards, against a backdrop of increased patient dependency and throughput. The RNs dual role means that instead of 'just' being an RN delivering direct care, they are increasingly expanding their role into ward management in the form of shift co-ordinator, because the solitary Ward Manager works 37.5 hours per week, and when on duty is often drawn away from the ward.

Allocating additional responsibilities to RN's is a cultural practice effective in maintaining, even lowering labour costs, but at what expense ?. These dual roles mean RN's are pulled further away from their role as direct patient carer in the Primary Nursing System, and as a result of backfilling Junior RN's are learning their 'secondary', co-ordinator / supervisory role is more important than their 'primary', direct patient care role.

The outcome of the dual role approach to getting through the workload is that RN's are soaking up modernization agendas with no consideration for the effect

on surgical patient care. Nevertheless management are happy because RN's are coping with modernization without additional costs to the trust, as a Ward Manager summed up in an earlier quote **I'm now carrying a ghost (fieldnotes)*, a term she used to refer to her ward being devoid of two shifts a week of a senior member of staff.

Conclusion:

Modernization of this Acute Trusts nurse labour process has resulted in Senior, experienced RN's 'doing more for more with less'²⁰⁴. The increased patient dependency and patient throughput on surgical wards has resulted in paralysis in the surgical nurse community, RNs can neither expand nor contract their role because they are just getting through the workload. The preceeding five year growth culture now culminates in the point at which expansion demands exceed the capacity of RN's to respond. RN's can't cope with any more demands on their role, as evidenced by the chaotic responses seen to a small anomaly in day to day ward functioning, when an RN rang in sick for a shift

*this morning a staff nurse rang in sick for the late shift, the ward co-ordinator went into overdrive to cover the late shift, ringing staff on their day off and ringing other wards to see if an experience RN was able to do an agency shift (fieldwork).

The overall effect of the sequential erosion of Senior RNs is a reduced nursing skill mix to care for an ever increasing dependent in patient ward case mix. Yet to the untrained eye, the general wards seem well staffed. This illusory façade of uniforms manning wards is a situation rarely detected by the average patient or visitor, it is a staffing illusion because employees don uniforms once traditionally the domain of RNs, today, apart from the Ward Manager, many staff wear uniforms of a similar nature, whose distinguishing features, their 'symbols of difference'²⁰⁵ which indicate their provinance and grade, for patients, their friends and relatives and others are indistinguishable, because the symbols are hidden from view due to the almost permanent use of plastic aprons. The Trusts ancilliary staff are now wearing the 'old' navy blue Ward Sisters uniforms, and a the new grade of assistant in the ward, the old Enrolled Nurse green uniforms, adding a new perspective to the concept 'recycling' in the NHS.

Implications for policy.

A key observation emanating from this research that should be brought into the forefront of the English NHS and NMC debates is the fact there are no national standards regarding the ratio of AfC professional grades (5-9) to AfC assistant grades (1-4) for staffing non critical care wards in the acute trust. In Braverman terms this is the ratio between the skilled, semi-skilled and unskilled [nursing] labour force, an anomalie with regards to the nursing establishment exposed in this empirical study.

The General Wards in this trust had 28 beds, because there were NO defined RN to acute surgical patient ratio, and NO defined ratio of RN (skilled) to HCAs (semi and un-skilled) the ratio was observed to range dramatically on a day to day and shift to shift basis, described at the beginning of this paper as the Gold, Silver and Bronze nursing labour process;

²⁰⁴ as a result of managers erosion of the nursing skill mix, against a backdrop of increasing numbers of more dependent surgical patients and an increase in the throughput of patients.

²⁰⁵ the badge, belt and for males epaulets.

- 1 RN to 7 patients [1:7] The 'Gold Service' Primary Nursing labour process for acutely ill hospitalised surgical patients.
- 1 RN to 14 patients [1:14] The 'Silver Service' Team Nursing labour process for acutely ill hospitalised surgical patients.
- 1 RN to 28 patients [1:28] 'Bronze Service' Task Allocation labour process for acutely ill hospitalised surgical patients.

This nursing establishment anomaly has not gone unnoticed in much literature in the public domain (Arthur and James 1994, Audit Commission 2001; Buchan and Calman 2004; Crossan and Ferguson 2005; ICN 2004; RCN 2006), begging answers to the following questions;

- What ratio of RNs to Assistants in non-critical care acute trust wards is a safe ratio ?,
- What is 'best practice' preparation for the new Assistant grades being employed in non-critical care acute trust wards?,

the latter question raised because the preparation of 'assistant' grades is currently marked by diversity rather than consensus, believe me I'm a Registered Nurse with 32 years continuous service.

References.

All references included in this paper are in the list of references in this thesis.

Appendix 38: Evidence available for auditing²⁰⁶ the research process and product.

- Daily Journal – maintained since commencing this research journey.
 - Total 54 on submission of the thesis
 - A4 fixed page books containing handwritten dialogue, notes, memorandum, copies of emails etc etc.
 - Catalogued 1-54 and stored.
- Catalogued literature used in the construction of the thesis and dissertation.
 - Boxed by topic / subject area eg Part I of thesis Era 1, Labour Process theory / Braverman.
- Handwritten notes from reviewing the literature.
- Lap-top database: Files / folders showing draft documents eg chapters / tables
- Official university correspondence (usually annually required processes):
 - progress reports with supervisor
 - independent review by a member of the School research team
 - graduate school letters
 - university enrolment documents
 - pathways documents from my own School of Health Dean
- Director of Studies supervisory records
- Ethical approval process documents
 - Letters from LREC
 - Letters from the Acute Trust R & D
 - Signed Consent Forms
- Fieldwork data (all catalogued and stored).
 - Fieldnotes
 - Trust documents
 - Tape recorded interviews & transcriptions.

²⁰⁶ There appear in the literature two audit processes that can be applied to qualitative research. The first is the process whereby within the ethnographic product the researcher makes the research process adequately visible so through audit it can be authenticated (Baillie 1997), which Slevin and Sines (1999) see that transparently presenting decisions on method selection and data analysis procedures allowing readers an opportunity to make a judgement regarding consistency of findings and to evaluate their truthfulness. The second has been described by Lincoln and Guba (1985) as a single audit to simultaneously determine dependability and confirmability, through an external auditor reviewing all documents used in the process of conducting and producing the research study. Rodgers and Cowles (1993) focus specifically on the fact that qualitative studies generate large volumes of data / documents in many forms and acknowledge that such data are important in providing an audit trail to substantiate trustworthiness.